Community Needs Evaluation

2012 Update – Davidson County, Tennessee

Metropolitan Social Services – Planning & Coordination

Metropolitan Government of Nashville and Davidson County

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Special thanks to Research Advisors for the Community Needs Evaluation

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Second Harvest Food Bank
Tennessee Fair Housing Council
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This document was printed at a cost of $13 per copy.

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Message from the Metropolitan Social Services Commission

Frank H. Boehm, M.D., Board Chairman

Metropolitan Social Services is pleased to present its 2012 Community Needs Evaluation Update. When it created its first Community Needs Evaluation in 2009, MSS established a systematic process for gathering, interpreting, and reporting data about social service needs and gaps in Davidson County.

Metropolitan Social Services' Planning & Coordination staff produced this fourth annual report to provide data and descriptive information about existing and projected unmet social service needs in Davidson County. The MSS Board of Commissioners determined that the focus of Planning & Coordination should be data driven as well as evidence based. Much as the practice of medicine is increasingly utilizing evidence base medicine to help establish appropriate medical treatment, MSS also believes that evidence based social service data is required to help our community make critical decisions on how to help the vulnerable among us.

In February of 2010, Mayor Karl Dean acknowledged the work of Metropolitan Social Services and charged the department to continue "conducting annual community needs assessments and organizing community-wide, public-private partnerships." The 2012 Community Needs Evaluation includes the topics: Food and Nutrition, Health and Human Development, Housing and Neighborhoods, Long-Term Services and Supports, and Workforce and Economic Opportunity. Because of the increasing number of adults who are disabled or frail elderly, Home and Community Based Services for Seniors/Adults has been included. The section has been renamed Long-Term Services and Supports, reflecting new federal terminology. Because of the increasing number of adults who are disabled or frail elderly, this update also includes a section on Long-Term Services and Supports.

Special thanks are due to the work of MSS Executive Director Renee Pratt and Planning & Coordination Director Dinah Gregory, as well as the entire Planning and Coordination staff of MSS. The MSS Board of Commissioners is pleased to share this document with Nashville's social service community. Questions should be emailed to MSSPC@nashville.gov

Sincerely,

Frank H. Boehm

Chairman, Board of Commissioners
Metropolitan Social Services

The Status of Davidson County

Nashville has been ranked highly for business climate, culture, startup business success, and as an overall best city. However, even in a city that continues to be recognized for achievement, there are significant disparities in the quality of life for Davidson County residents.

Depending on age, race, ethnicity, gender and other characteristics, there is a tremendous variation in the social and economic circumstances for Nashvillians. Similar to the U. S. recovery from the recession, recovery is continuing in Davidson County, but at a relatively slow rate. For example, the U. S. Census Bureau's American Community Survey reported that:

- The median income in Davidson County dropped from $50,164 in 2007 to $43,556 in 2011.
- Per capita income was $30,318 in 2007 and dropped to a low of $26,812 in 2010, and was slightly higher in 2011 at $27,480. The per capita income in Davidson County is higher than the U. S. ($26,708) and the State of Tennessee ($23,320).
- During 2011, the poverty rate for all people in Davidson County (19.3%) was higher than the U. S. (15.9%) and the State of Tennessee (18.3%).
- The poverty rate for Davidson County residents who were under age 18 was 30.5% in 2011.
- The geographic distribution of people in poverty is uneven across Davidson County, with poverty in Metropolitan Council Districts varying from 2.8% in District 34 to 43.0% in District 19.
- There have been recent improvements in employment prospects in Davidson County. After reaching 8.9% in 2009 and 2010, the unemployment rate is down to 5.7%. In 2012, 19,850 more people are employed than in 2009 at the height of the recession.
- During the four years in which Metropolitan Social Services has conducted the Grassroots Community Survey, the top two needs each year were Workforce and Economic Opportunity and Housing and Related Assistance. Each year Food was the third most frequently identified.

The 2012 Community Needs Evaluation provides specific information about the issues of Food and Nutrition, Health and Human Development, Housing and Neighborhoods, Long-Term Services and Supports, and Workforce and Economic Opportunity, including the challenges faced by residents of Davidson County.

This annual evaluation again provides information about the importance of using Evidence-Based Practices. It includes examples of Best Practices for each issue area, which could be used to improve and enhance the services provided to Davidson County residents in need.

Methodology

The 2012 Community Needs Evaluation Update includes information about issues similar to those in the 2011 evaluation: Child Care, Economic Opportunity, Food, Health, Home and Community Services, Housing, Neighborhood Development and Workforce Development. In an effort to use a broader approach and report on data and trends in the most organized way, some issue areas have been combined or adjusted. There are other issues related to quality of life that are beyond the scope of this evaluation, including education, crime and justice, domestic violence and others. Changes include:

- Child Care is now part of the section for Health and Human Development. Many of the issues related to child care were about early childhood development, which fits within the context of Health and Human Development.

- Neighborhood Development is now included in the closely related section of Housing.

- Home and Community Based Services-Seniors/Adults is now called Long-Term Services and Supports (LTSS) (Non-institutionally based), reflecting new terminology being used by the federal government. (LTSS is a newer term that refers to a broad range of supportive services needed by people who have limitations in their capacity for self-care because of a physical, cognitive, or mental disability or condition. While the term could be used more broadly to include residential care and children with disabilities, the Community Needs Evaluation will focus on non-institutionally based services for seniors/adults.)

Primary Data

For the fourth year, primary research was conducted through a Grassroots Community Needs Survey, administered in Davidson County, to customers at specific social/human service programs.

- The first Grassroots Community Survey was conducted in 2009 with customers of the Tennessee Department of Human Services (Davidson County Office), Catholic Charities, the Nashville Career Advancement Center, Second Harvest Food Bank, Siloam Family Health Center, the Metropolitan Action Commission, and Metropolitan Social Services, with 1,737 respondents.

- In 2010, the same Grassroots Community Needs Survey was administered to participants of the Volunteer Income Tax Assistance sites, operated by the Nashville Alliance for Financial Independence (an initiative of United Way), with 1,787 respondents. (This survey was completed prior to Davidson County's May 2010 flood.)

- In 2011, the Grassroots Survey was slightly modified to add questions about Health and Neighborhood Development. It was conducted primarily with customers of the Tennessee Department of Human Services (Davidson County Office) and with some residents at Urban Housing Solutions, with a total of 768 respondents.

- In 2012, the Grassroots Survey was administered to 475 customers from a variety of social service organizations, including Catholic Charities of Tennessee, The Next Door, Siloam Clinic, Goodwill Industries, Conexion Americas, McGruder Family Resource Center, Christian Women's Job Corps, the Opportunities Industrialization Center, Metropolitan Action Commission and Metropolitan Social Services.

The survey asked Davidson County residents to identify the greatest need in each issue and provided them with an opportunity to identify additional needs. One question on the survey asked respondents to identify which issue had the largest gap between the services now available and what the community needs. This document contains data about the types of needs identified by respondents in each relevant section.

While other questions asked respondents to identify the most important needs from within issue groups, one question asked respondents to choose among the seven issue areas and identify the one with the greatest gap between available services and the needs in the community. Findings from the survey are included in relevant sections of this document.

Secondary Data

Data was compiled from the U.S. Census Bureau, particularly the 2000 and 2010 Decennial Census, the annual American Community Surveys (ACS), and 3-year and 5-year ACS summaries, as well as from other government and private research sources. The 2000, 2010 and other decennial census products include actual population counts and basic characteristics, while the American Community Surveys provide additional social, economic, demographic and housing characteristics.

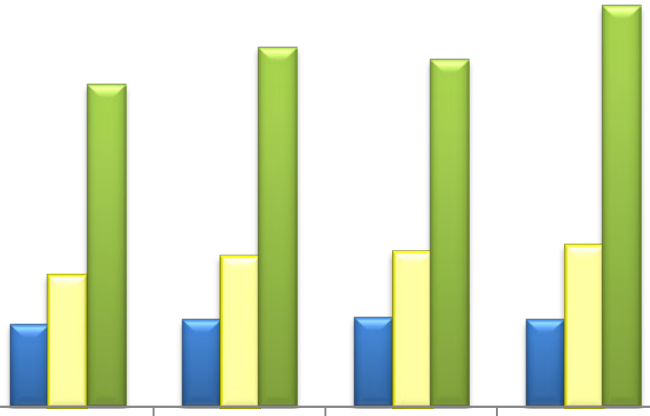
American Community Surveys, both annual and multiyear, are estimates, based on samples of the population and have varying margins of error, as specified by the Census Bureau. The Census Bureau indicates that the longer reporting periods provide more accurate and reliable information than the annual information. However, annual data is more useful to demonstrate trends over time. The 5-year ACS summaries included the geographic areas smaller than county level, so these are used in maps comparing data across 35 Metropolitan Council Districts and 161 census tracts in Davidson County. In some cases, actual population counts from decennial Census data is compared with American Community Survey estimates. While those comparisons are less than ideal, they are provided to show trends on measures more frequently than 10 year intervals.

New data products are regularly released by the U. S. Census Bureau and other agencies, and future updates of this report will include data as it becomes available. The tables, charts, and narrative descriptions reflect a wide range of demographic, economic, social, and other characteristics of Davidson County. Additional information is available online and more will be added when available.
http://www.nashville.gov/Social-Services.aspx

Demographic and Social Profile

Between 1990 and 2011, Davidson County experienced an overall population increase in the number of people, while the number has remained stable from 2008 through 2011. From 1990 to 2011, there was a slight increase in the number of families (related people who live together), while there was a greater increase in the number of households, as shown in Chart 1.

Chart 1: Number of Families, Households and People
Davidson County, 1990, 2000, 2005, 2011



	1990	2000	2005	2011
Families	131,395	138,106	142,376	138,392
Households	207,530	237,405	244,696	254,655
People	510,784	569,891	549,850	635,475

Source: U. S. Census Bureau (1990 and 2000 Census; 2005, 2011 American Community Survey)

The table below shows the average size of households and families in Davidson County. The size of households has been relatively stable and there has been a slight increase in family size.

Size of Household by Type	1990	2000	2005	2011
Average household size	2.36	2.30	2.25	2.40
Average family size	2.97	2.96	2.93	3.30

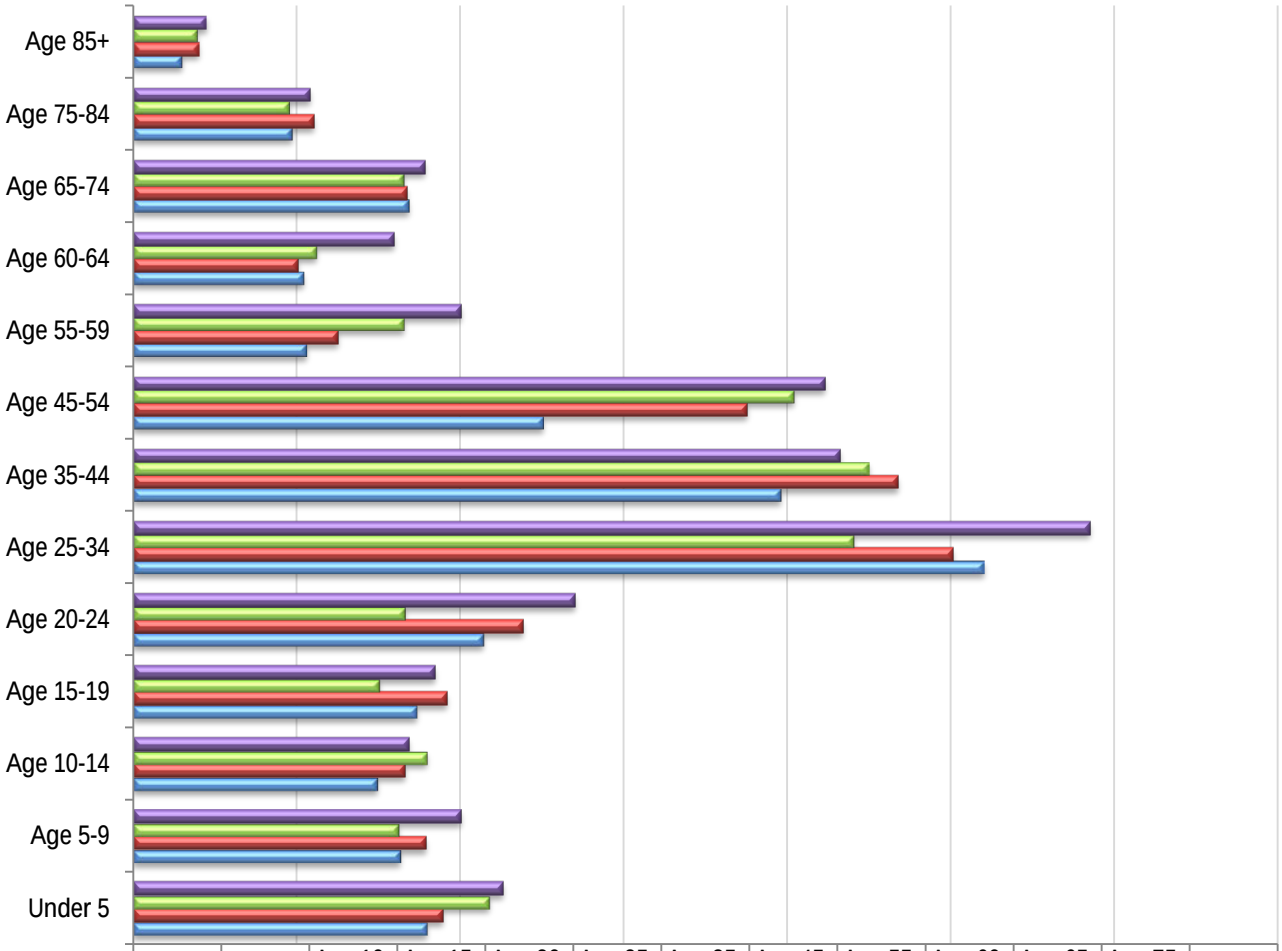
Each year, the U.S. Census and American Community Survey estimated slightly more females than males, as shown in the table below.

Gender	1990	2000	2005	2011
Male	242,492	275,865	266,684	307,726
Female	268,292	294,026	283,166	327,749

Chart 2 shows the number of people in Davidson County by age categories for selected years since 1990. The most noticeable increase for 2011 was in the 25-34 age group.

Chart 2: Number of People by Age Categories

Davidson County, 1990, 2000, 2005, 2011



	Under 5	Age 5-9	Age 10-14	Age 15-19	Age 20-24	Age 25-34	Age 35-44	Age 45-54	Age 55-59	Age 60-64	Age 65-74	Age 75-84	Age 85+
2011	45,119	40,035	33,680	36,858	54,015	116,927	86,425	84,518	40,035	31,774	35,587	21,606	8,897
2005	43,552	32,463	35,934	30,117	33,259	88,094	89,975	80,783	33,126	22,441	33,090	19,106	7,900
2000	37,813	35,724	33,232	38,331	47,545	100,187	93,499	75,034	24,968	20,114	33,398	22,044	8,002
1990	35,943	32,690	29,898	34,714	42,831	104,040	79,173	50,159	21,242	20,865	33,731	19,471	6,027

Source: U. S. Census Bureau (1990 and 2000 Census; 2005, 2011 American Community Survey)

The median age in Davidson County was 33.9 in 2011, slightly less than both 2000 and 2005.

	2000	2005	2011
Median age	34.1	36.2	33.9

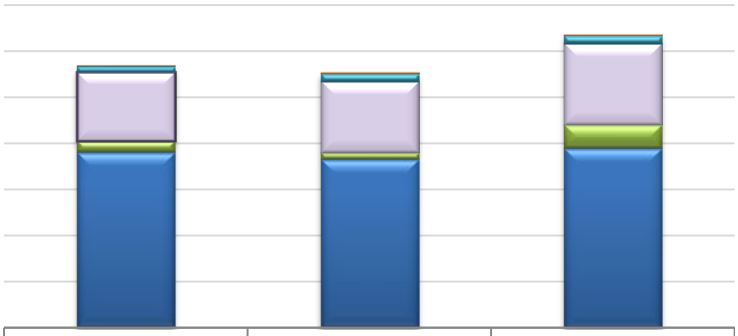
The table below shows the percentage of people by age category by the U. S., Tennessee and Davidson County, according to the 2007-2011 American Community Survey 5-Year Summary. The category for ages 25-34 is noticeably larger in Davidson County than for either Tennessee or the U. S., while the older categories are smaller.

Age Categories	United States	Tennessee	Davidson County
Under 5 years	6.6%	6.4%	7.1%
5 to 9 years	6.6%	6.5%	6.2%
10 to 14 years	6.7%	6.7%	5.3%
15 to 19 years	7.2%	6.9%	6.3%
20 to 24 years	7.0%	6.7%	8.6%
25 to 34 years	13.3%	13.1%	18.0%
35 to 44 years	13.6%	13.7%	13.9%
45 to 54 years	14.5%	14.5%	13.6%
55 to 59 years	6.3%	6.4%	6.0%
60 to 64 years	5.3%	5.7%	4.5%
65 to 74 years	6.9%	7.5%	5.5%
75 to 84 years	4.3%	4.2%	3.5%
85 years and over	1.7%	1.5%	1.5%

Chart 3 shows the Davidson County population by race for 2000, 2005 and 2011. While most categories remained stable or reflected a slight increase, a more rapidly growing category was "More than one race or other," which doubled between 2000 and 2011.

Chart 3: Population by Racial Composition

Davidson County, 2000, 2005, 2011

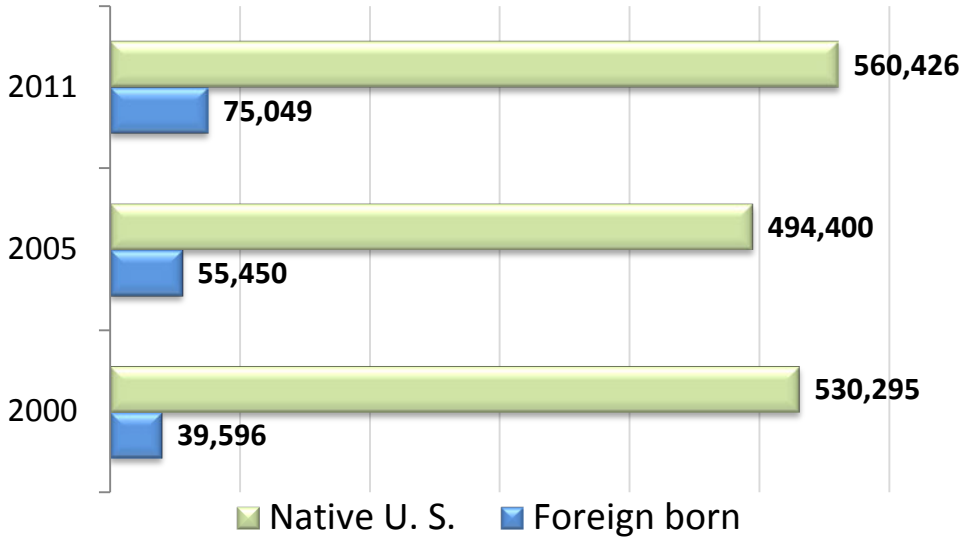


	2000	2005	2011
Amer. Ind., Alaska Nat.	1,679	3,049	1,947
Asian	13,275	17,758	18,144
Black	147,696	153,761	175,681
More than one race or other	25,055	14,757	51,340
Nat. Hawaiian, Pac.Islander	403	0	310
White	381,783	365,863	389,807

Source: U. S. Census Bureau (2000 Census; 2005, 2011 American Community Survey)

Chart 4 shows that the number of foreign-born residents increased at a faster rate than the general population in Davidson County between 2000 and 2011. The number of naturalized citizens in Davidson County increased from 9,891 in 2000 to 12,893 in 2005 and to 24,131 in 2011.

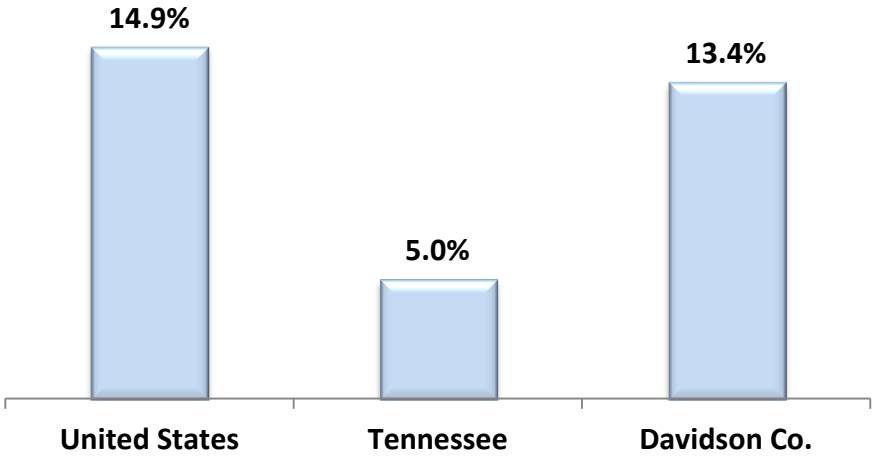
Chart 4: Number of Native-Born and Foreign-Born
Davidson County, 2000, 2005, 2007



Source: U. S. Census Bureau (1990 and 2000 Census; 2005, 2011 American Community Survey)

The percentage of foreign-born residents in Davidson County is slightly lower than for the U.S., but is significantly higher than for the State of Tennessee. The number of foreign-born people in Tennessee is extremely low, compared to either Davidson County or the U. S.

Chart 5: Percent Foreign-Born
U. S., Tennessee, Davidson County, 2011



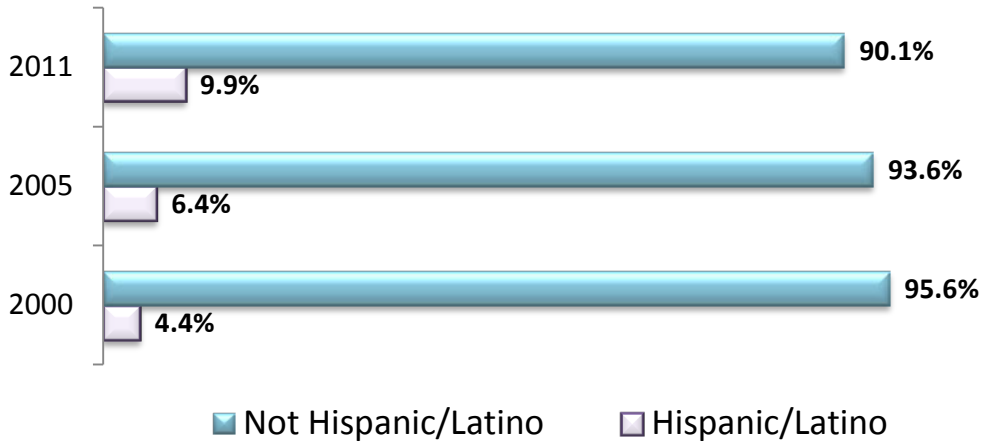
Source: U. S. Census Bureau (2011 American Community Survey)

As shown below, the primary region of birth for foreign-born Davidson County residents was Latin America, followed by Asia (U. S. Census Bureau).

	2000	2005	2011
Oceania	209	0	300
Northern America	1,094	1,362	1,276
Europe	5,038	3,894	6,604
Africa	4,199	9,705	9,156
Asia	12,800	17,034	22,215
Latin America	16,256	23,455	35,498

Chart 6 shows that the Hispanic/Latino population has grown significantly since 2000. However, the Hispanic/Latino population is less than 10% of the total population in Davidson County.

Chart 6: Hispanic/Latino and Non-Hispanic/Latino Population
Davidson County, 2000, 2005, 2011



Source: U. S. Census Bureau, 2011 American Community Survey

The table below shows the composition of nationality groups for the Hispanic/Latino population from the 2011 American Community Survey.

Hispanic or Latino (of any race)	U. S.	Tennessee	Davidson Co.
Mexican	10.8%	3.1%	6.3%
Puerto Rican	1.6%	0.4%	0.3%
Cuban	0.6%	0.1%	0.3%
Other Hispanic or Latino	3.7%	1.1%	2.9%

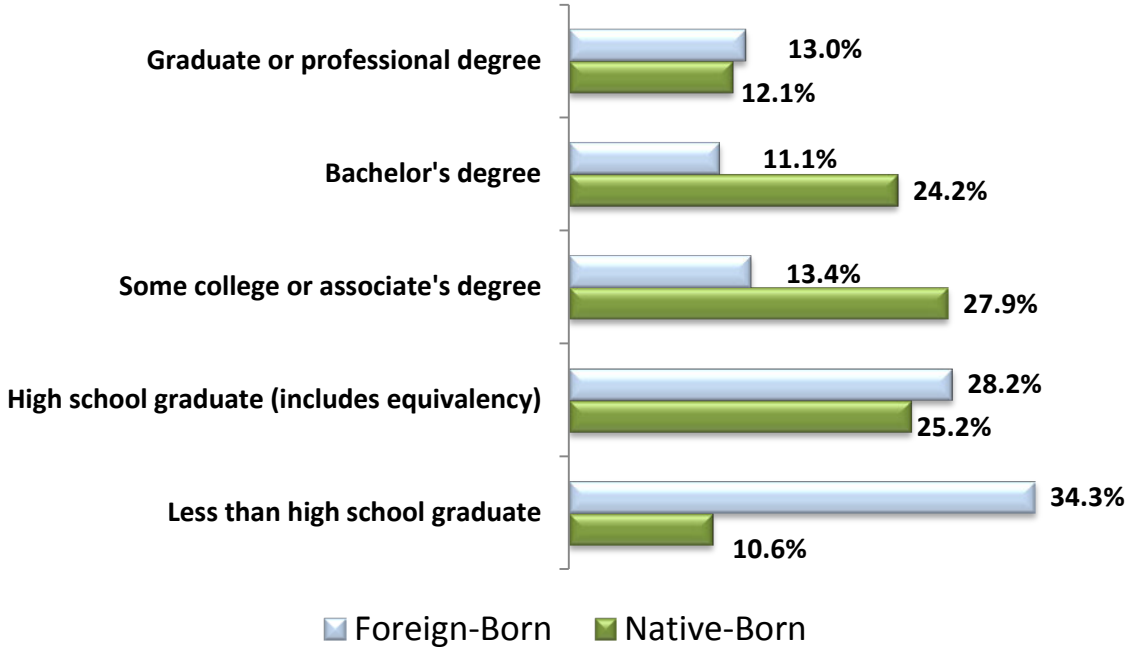
There are other differences between foreign-born and native-born residents, as well as differences across countries of origin. For example, according to 2011 American Community Survey estimates for Davidson County:

- Foreign-born residents are more likely to be in a married-couple family (57.0%) than the native-born residents (45.6%).
- Foreign-born residents are more likely to live in families with related children under age 18 (39.0%) compared to native-born residents (21.9%).
- The average household size for foreign-born residents (3.52) is larger than for native-born (2.26).
- The average family size for foreign-born residents (4.05) is larger than for native-born (3.09).

Chart 7 shows the different pattern of educational attainment by the native-born and foreign-born population. Foreign-born residents of Davidson County are much more likely to lack a high school education (34.4%) than native-born (10.6%), which may be related to the number of refugees and casual laborers (such as seasonal employees).

However, among residents who have obtained a graduate or professional degree, a slightly higher percentage of foreign-born residents (13.0%) have advanced degrees than the native-born (12.1%), possibly because they are attracted to the large number of institutions of higher education and medical centers in the area.

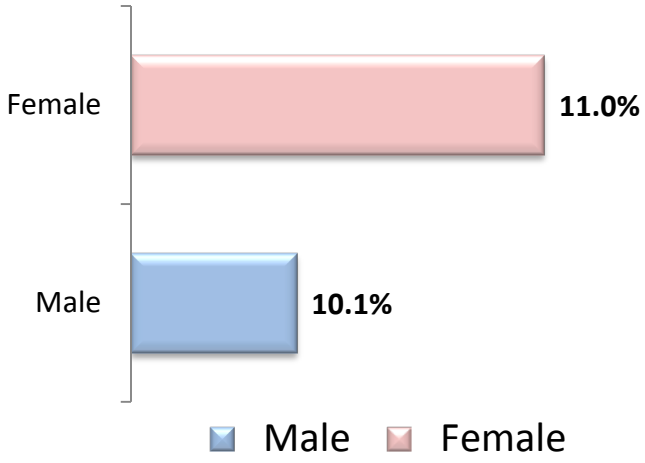
Chart 7: Educational Attainment by Native/Foreign Born
Davidson County, 2011



Source: U. S. Census Bureau (2011 American Community Survey)

The 2011 American Community Survey estimates that a slightly higher percent of females are disabled (11.0%) than males (10.1%) in Davidson. Additional information about the increase of disabilities for those who are aging and the types of disabilities they have are included later in this report.

Chart 8: Percent With A Disability by Gender
Davidson County, 2011



Source: U. S. Census Bureau (2011 American Community Survey)

According to estimates from the 2011 American Community Survey, among the racial categories, the percentage with a disability varies, as shown in the table below. In terms of ethnicity, 5.1% of the Hispanic/Latino population had a disability.

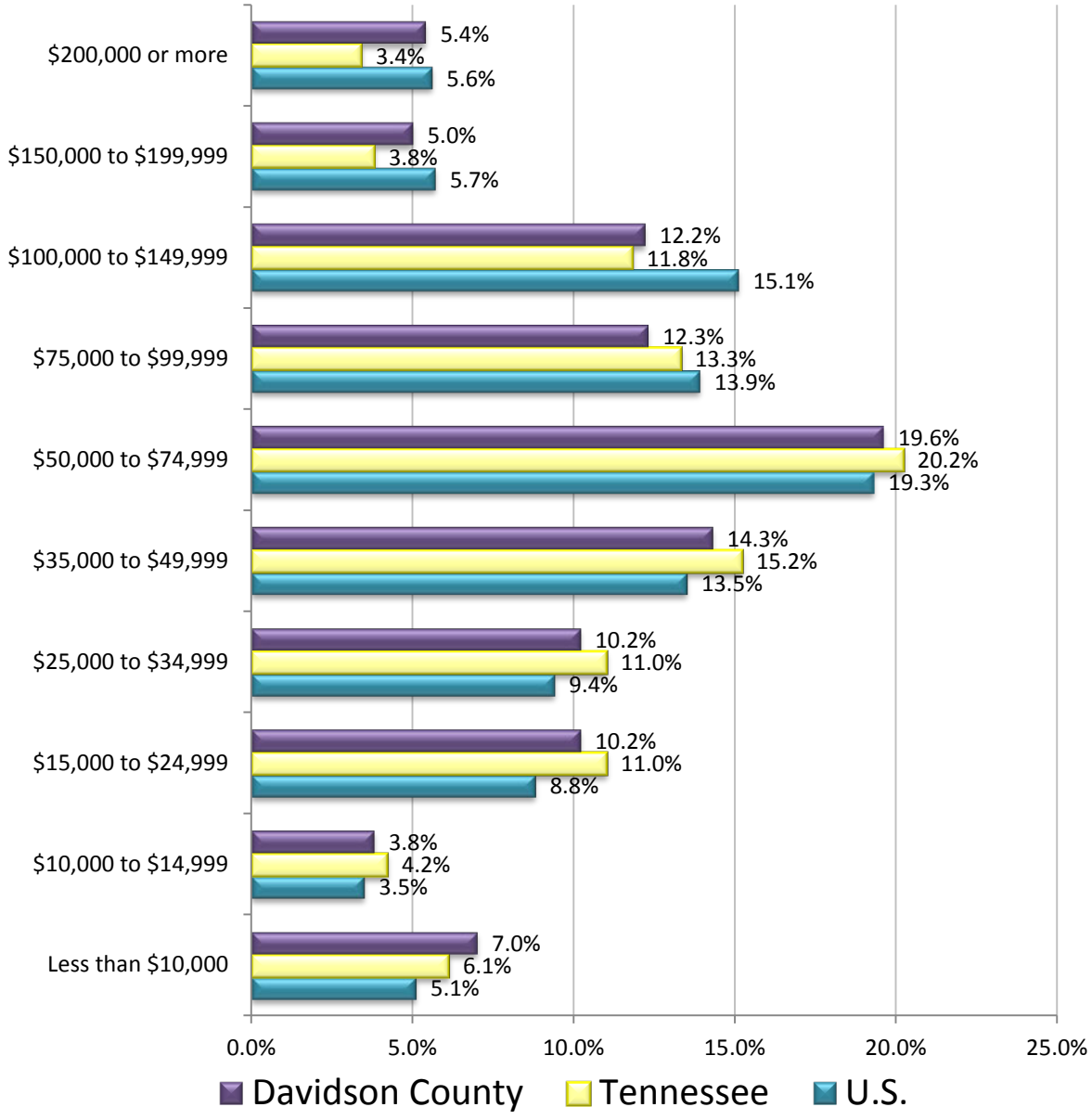
	% With Disability
American Indian and Alaska Native	0.0%
Asian	4.7%
Black or African American alone	11.1%
Native Hawaiian and Other Pacific Islander	0.0%
Other	4.5%
Two or More Races	7.5%
White	11.3%

Socioeconomic Profile

Chart 8 shows the percentage of families by income categories for Davidson County, Tennessee and the U.S. for the period 2007-2011. During that period, the largest percentage for each geographic location was for the family income category $50,000-$74,999. This and other measures of income are adjusted for inflation by the U. S. Census Bureau.

Chart 8: Percentage of Families by Income Category

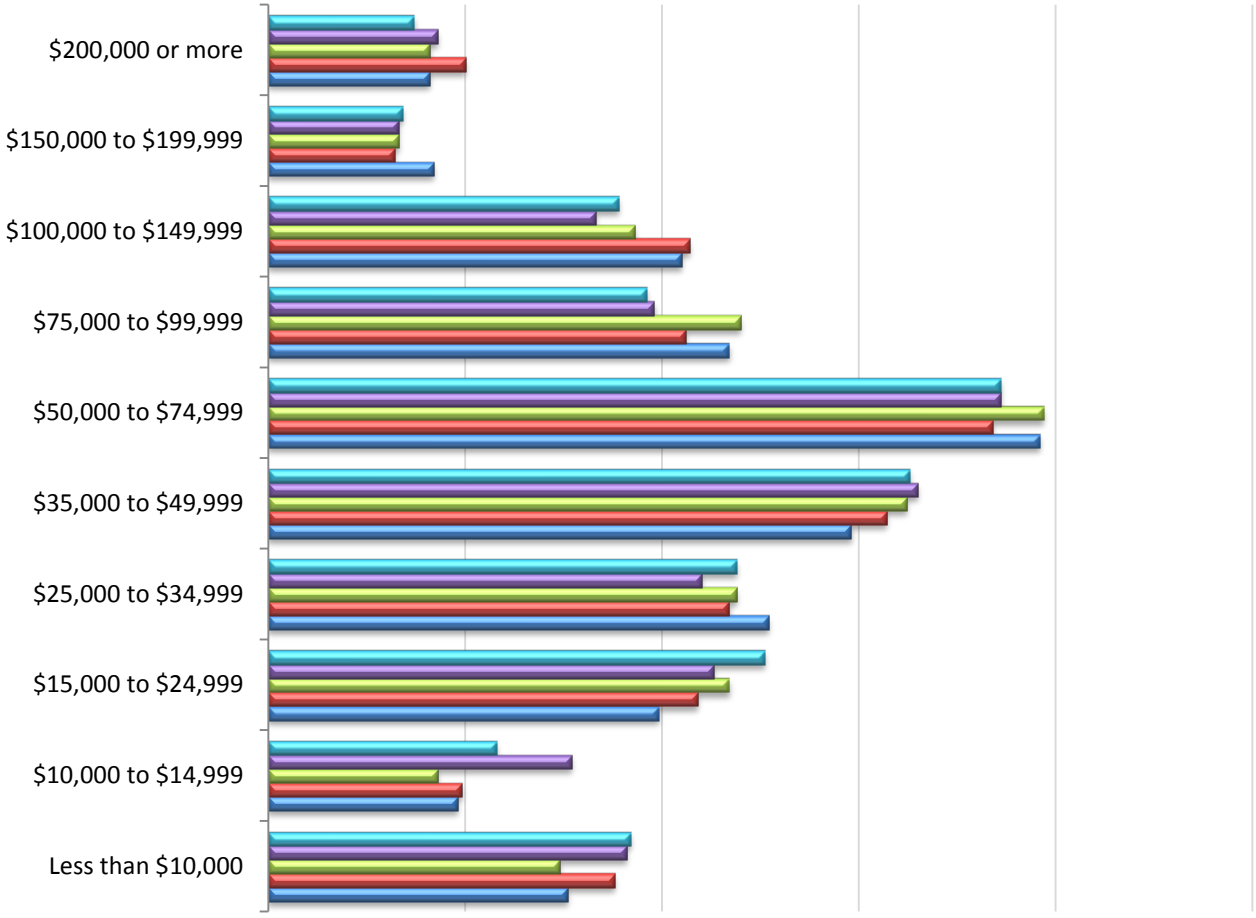
U. S., Tennessee, Davidson County, 2007-2011



Source: U. S. Census Bureau (2007-2011 American Community, 5-Year Summary)

Families are households in which members related by birth, adoption or marriage reside together, while households consist of all the people who occupy a housing unit (which could include an individual living alone, as well as lodgers or other unrelated people who share the noninstitutional housing unit). As noted above, the average household size is generally smaller than average family size (2.4 average household size and 3.3 average family size for Davidson County in 2011), which may partly be due to individuals being counted as households rather than families. Chart 9 shows the percentage of Davidson County households by income category for individual years from 2007 through 2011.

Chart 9: Percentage of Households by Income Category
Davidson County, 2007-2011



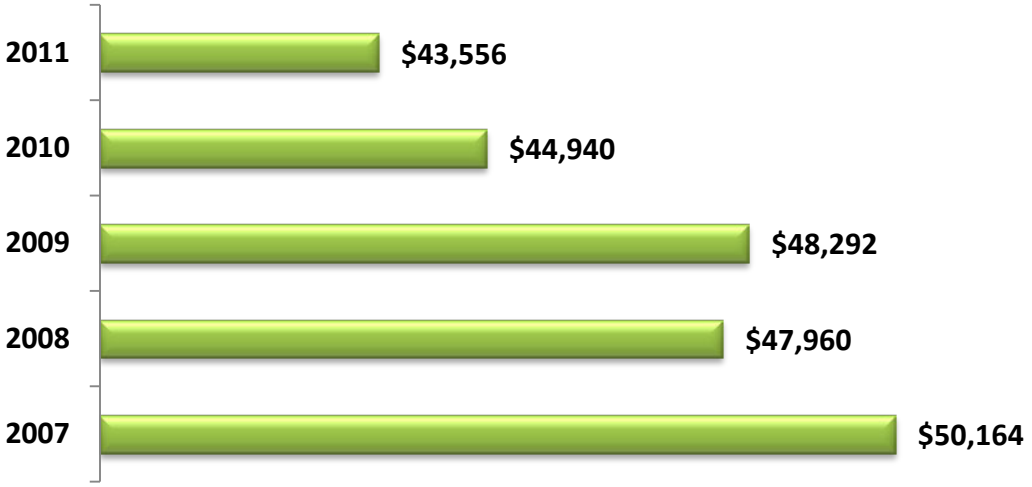
	Less than $10,000	$10,000 to $14,999	$15,000 to $24,999	$25,000 to $34,999	$35,000 to $49,999	$50,000 to $74,999	$75,000 to $99,999	$100,000 to $149,999	$150,000 to $199,999	$200,000 or more
2011	9.2%	5.8%	12.6%	11.9%	16.3%	18.6%	9.6%	8.9%	3.4%	3.7%
2010	9.1%	7.7%	11.3%	11.0%	16.5%	18.6%	9.8%	8.3%	3.3%	4.3%
2009	7.4%	4.3%	11.7%	11.9%	16.2%	19.7%	12.0%	9.3%	3.3%	4.1%
2008	8.8%	4.9%	10.9%	11.7%	15.7%	18.4%	10.6%	10.7%	3.2%	5.0%
2007	7.6%	4.8%	9.9%	12.7%	14.8%	19.6%	11.7%	10.5%	4.2%	4.1%

Source: U. S. Census Bureau (2007-2011 American Community, 5-Year Summary)

Chart 10 shows that the median household income for Davidson County has experienced an overall decline beginning around the time of the recession in 2007. The Workforce section describes the reduction in the unemployment rate in 2012, which would likely be reflected in the 2012 data, schedule for release in Fall 2013. For U. S. Census Bureau definitions of median, mean, per capita income and related definitions, please see pages 14-15 of the 2011 Community Needs Evaluation.

Chart 10: Median Household Income

Davidson County, 2007-2010



Source: U. S. Census Bureau (2007, 2008, 2009, 2010, 2011 American Community Surveys)

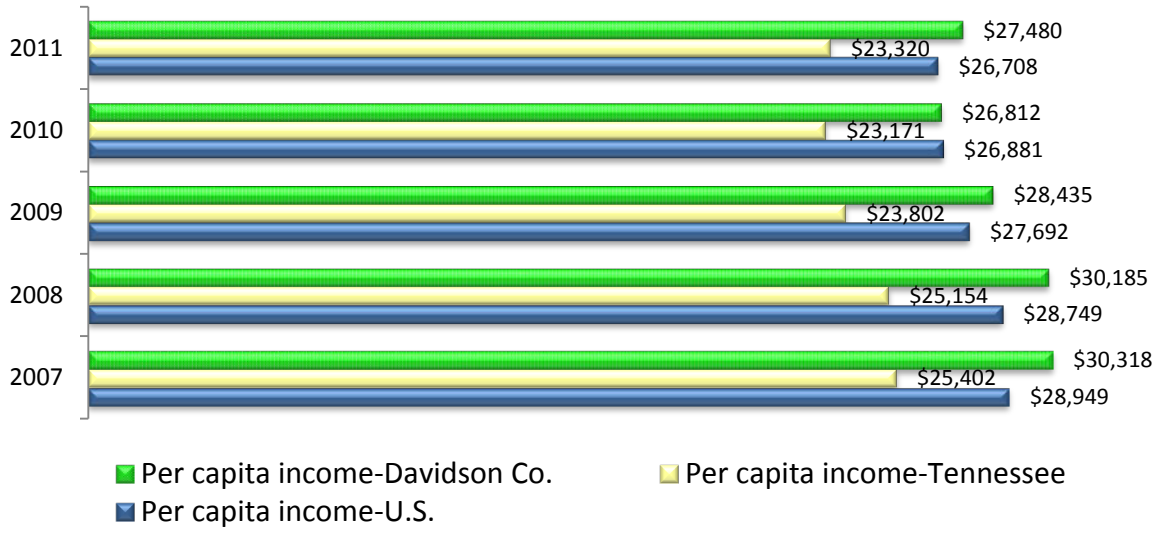
The table below compares the mean household income of the U.S., Tennessee and Davidson County across the 5-year period of 2007 through 2011 that generally shows declines from previous years.

Mean Household Income	2007	2008	2009	2010	2011
United States	$ 75,056	$ 74,541	$ 72,261	$ 70,412	$ 69,821
Tennessee	$ 63,092	$ 62,443	$ 59,549	$ 58,628	$ 58,400
Davidson County	$ 71,359	$ 71,154	$ 67,489	$ 64,746	$ 64,276

Although the mean household income for Davidson County was less than the U.S. for the past 5 years, the per capita income was higher for Davidson County than for the U. S. Chart 11 shows that the per capita income in Davidson County is higher than in Tennessee for the years from 2007 through 2011, and higher than in the U. S (except for one year in which it was slightly lower). The map shows the per capita income by Metropolitan Council Districts, based on estimates from the 5-Year Summary of the 2007-2011 American Community Survey, which is a slightly different data set.

Chart 11: Per Capita Income

Davidson County, Tennessee, U.S., 2007-2011



Source: U. S. Census Bureau (2007, 2008, 2009, 2010, 2011 American Community Surveys)

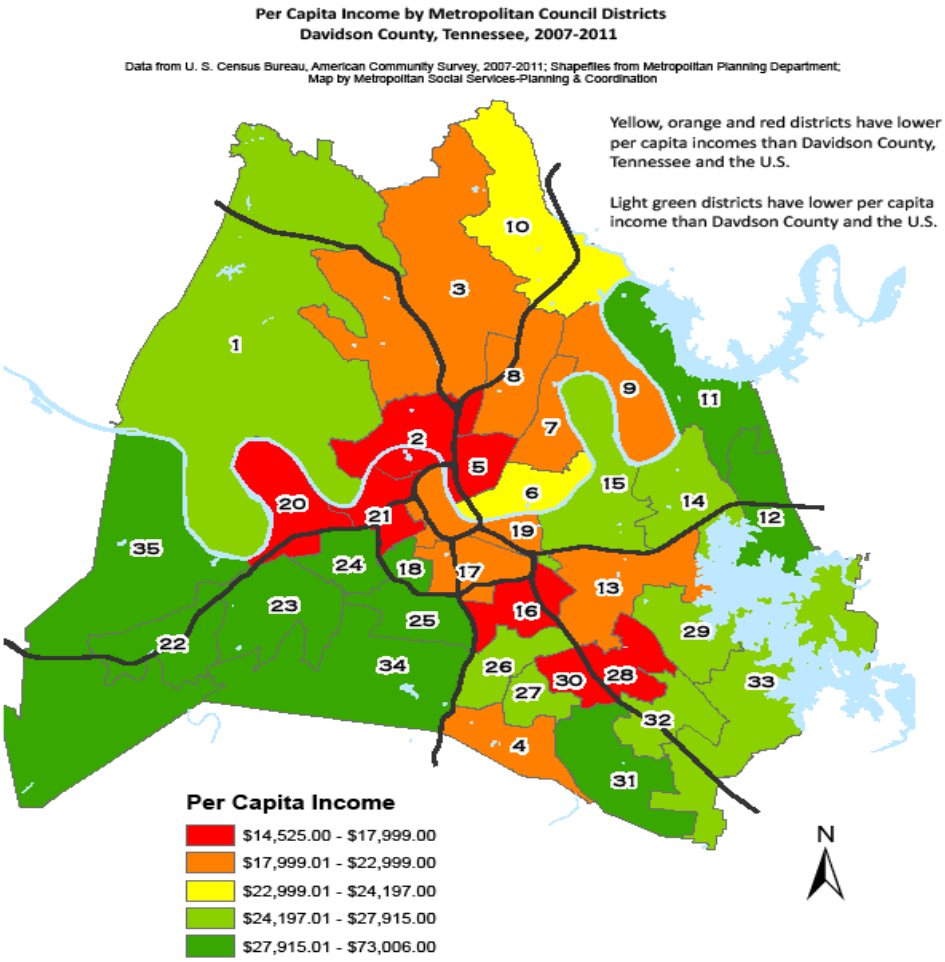
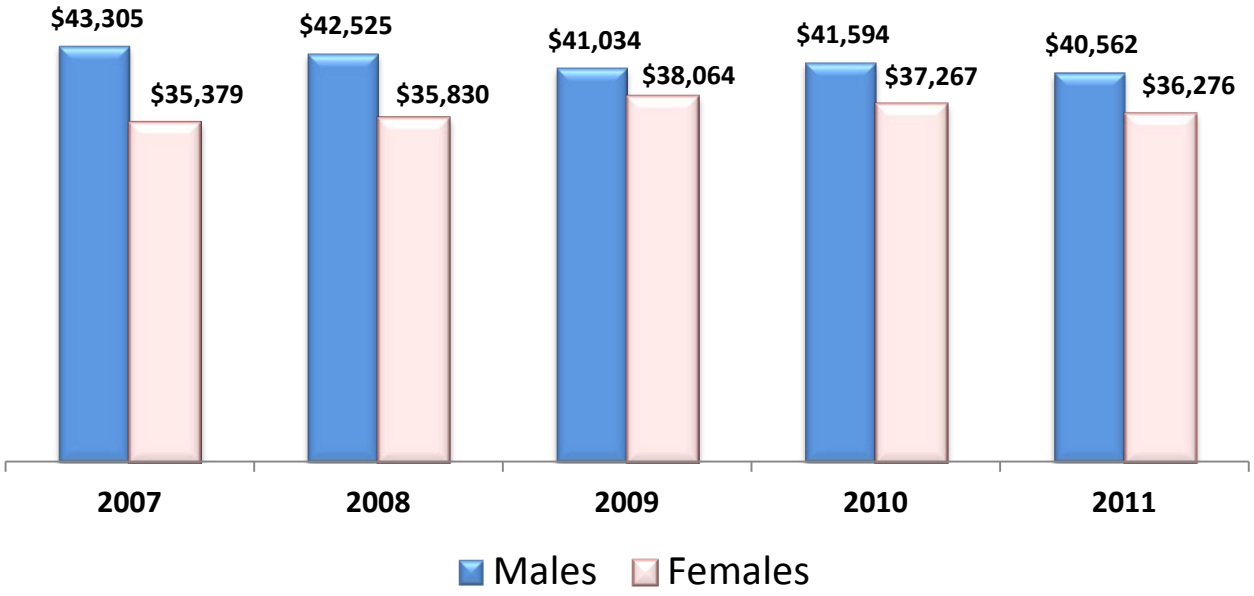


Chart 12 compares the median earnings for full-time year-around workers in Davidson County by gender and shows that females earned about 87% of what males earned during this period.

Chart 12: Median Earnings for Full-Time Year-Around Workers by Gender
Davidson County, 2007-2011



Source: U. S. Census Bureau (2007, 2008, 2009, 2010, 2011 American Community Surveys)

The tables below show the percentage of the population receiving Social Security Retirement Income, Supplemental Security Income and Public Cash Assistance Income. Davidson County's percentages of people with either Social Security Retirement Income or Supplemental Security Income are consistently lower than Tennessee and the U. S. This is likely due to Davidson County having a lower percentage (10.5%) of people over 65 in Davidson County than in Tennessee (13.3%) or the U. S. (12.9%) from 2007-2011.

The percentage of people with Cash Public Assistance Income has fluctuated and has been smaller and more consistent in all three jurisdictions and across the 5-year period.

With Social Security Retirement Income	2007	2008	2009	2010	2011
United States	17.5%	17.2%	17.4%	17.5%	17.7%
Tennessee	17.3%	17.6%	17.7%	18.2%	18.4%
Davidson County	14.0%	15.0%	12.9%	12.8%	13.8%

With Supplemental Security Income	2007	2008	2009	2010	2011
United States	4.1%	3.5%	3.6%	5.1%	5.3%
Tennessee	4.7%	3.7%	4.1%	5.6%	5.6%
Davidson County	3.4%	3.5%	3.1%	4.3%	4.1%

With Cash Public Assistance Income	2007	2008	2009	2010	2011
United States	2.1%	2.3%	2.6%	2.9%	2.9%
Tennessee	2.6%	2.4%	2.7%	2.9%	3.3%
Davidson County	2.4%	1.4%	1.9%	3.1%	3.3%

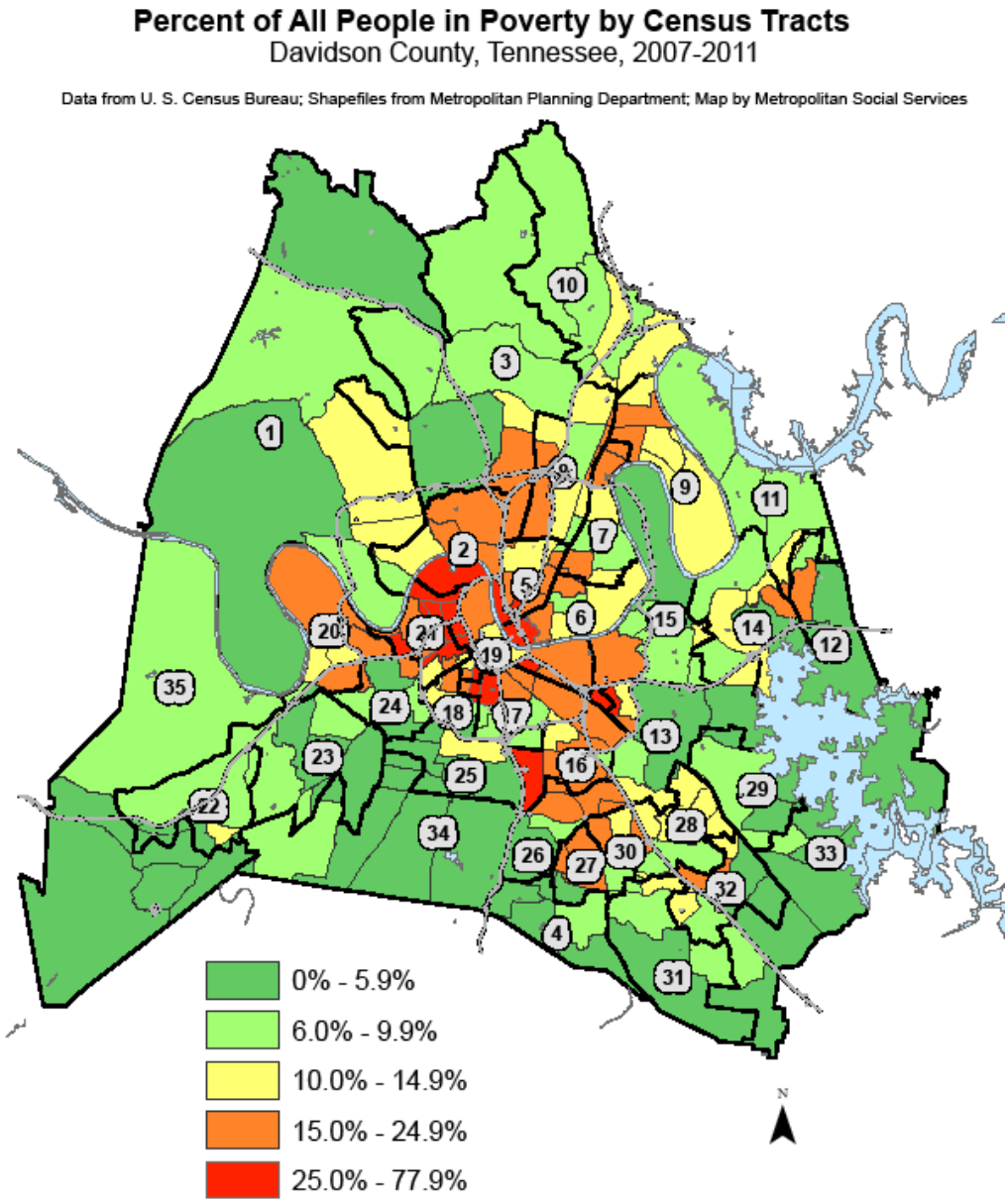
Income varies by several characteristics, such as age, race, educational attainment. The level of income is not evenly distributed throughout Davidson County. The table below shows the median household, family and nonfamily income by Metropolitan Council Districts, based on data from the 2007-2011 American Community Survey 5-Year Summary.

The lowest median household income is in District 17 at $19,455, compared to the highest of $108,785 in District 34. (A family household includes people who are related to each other by birth, adoption or marriage. A nonfamily household could include people who are not related to each other or a person living alone.)

Additional income and economic characteristic data is available in the Data Snapshot section and on the Metropolitan Social Services web site.
http://www.nashville.gov/Social-Services.aspx

Metropolitan Council District	Median Household Income	Median Family Income	Median Nonfamily Income
District 1	$ 56,824	$ 65,840	$ 32,589
District 2	$ 28,454	$ 32,636	$ 23,194
District 3	$ 40,971	$ 47,714	$ 32,273
District 4	$ 35,646	$ 43,599	$ 22,393
District 5	$ 26,887	$ 28,526	$ 21,540
District 6	$ 36,415	$ 40,333	$ 32,200
District 7	$ 36,167	$ 47,341	$ 26,801
District 8	$ 42,429	$ 50,597	$ 33,413
District 9	$ 35,538	$ 45,097	$ 25,351
District 10	$ 46,183	$ 51,600	$ 36,411
District 11	$ 47,463	$ 61,635	$ 24,060
District 12	$ 55,493	$ 73,500	$ 38,271

District 13	$ 44,188	$ 47,315	$ 37,366
District 14	$ 45,756	$ 53,630	$ 38,030
District 15	$ 46,577	$ 51,039	$ 41,090
District 16	$ 33,484	$ 38,449	$ 28,602
District 17	$ 19,455	$ 30,205	$ 15,757
District 18	$ 60,166	$ 112,946	$ 37,196
District 19	$ 23,971	$ 26,204	$ 22,957
District 20	$ 40,025	$ 42,653	$ 32,525
District 21	$ 26,341	$ 27,612	$ 25,445
District 22	$ 50,948	$ 65,214	$ 40,616
District 23	$ 73,838	$ 121,326	$ 47,083
District 24	$ 59,049	$ 84,220	$ 44,593
District 25	$ 73,903	$ 114,496	$ 48,042
District 26	$ 45,658	$ 56,585	$ 32,824
District 27	$ 44,268	$ 46,573	$ 40,875
District 28	$ 41,524	$ 47,407	$ 33,250
District 29	$ 50,765	$ 60,955	$ 39,100
District 30	$ 37,642	$ 39,926	$ 30,394
District 31	$ 76,991	$ 84,480	$ 54,289
District 32	$ 50,461	$ 56,477	$ 39,040
District 33	$ 44,329	$ 58,256	$ 32,386
District 34	$ 108,785	$ 140,074	$ 57,468
District 35	$ 88,930	$ 99,868	$ 60,240



This map compares the rates of poverty across the 161 census tracts in Davidson County, using data from the 2007-2011 American Community Survey 5-Year Summary. Metropolitan Council Districts are also shown.

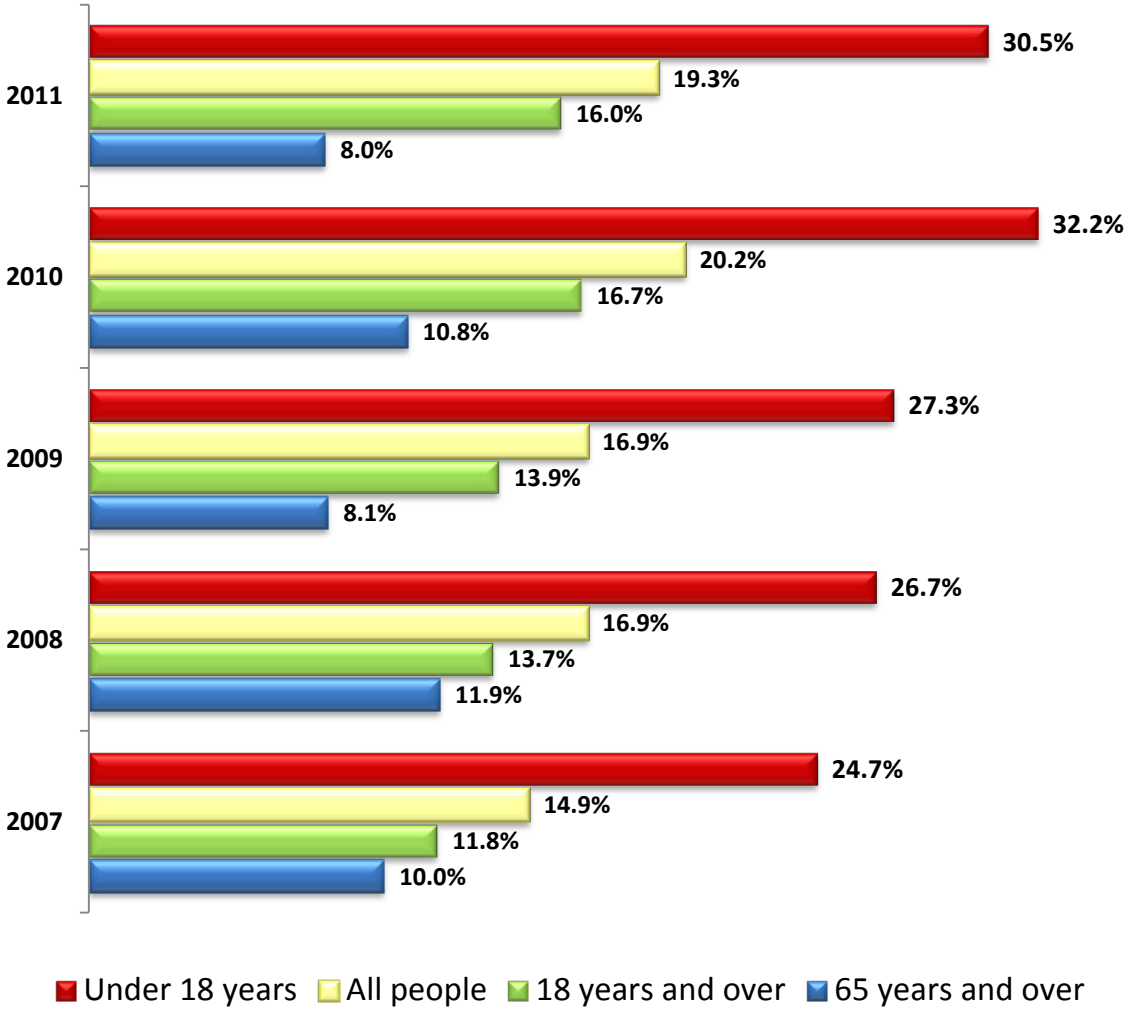
Chart 13 shows that the rate of poverty in Davidson County for all people decreased slightly from 2010 to 2011. However, it remains higher than the poverty rate for Tennessee and the U.S. The poverty rate for all categories decreased for Davidson County from 2010 to 2011, but generally remains higher than in the immediately preceding years. The highest rate of poverty each year is among people who are under 18 years of age.

As discussed in the section on the Supplemental Poverty Measure, the official poverty measure reflects only the number in the household or family and the pre-tax income. When additional factors are considered, the supplemental rate is somewhat different by age categories. For example, if the

medical out-of-pocket expenses are factored in, the supplemental poverty rate is higher for older persons because they typically have greater medical expenses. Similarly, when the in-kind federal programs (more often used by those who are younger) are considered, the poverty rate for those under age 18 decreased. (Unless otherwise indicated, the data used is based on the official poverty measure, which is also used for determining eligibility for many programs.)

Chart 13: Percentage of People in Poverty

Davidson County, 2007-2011

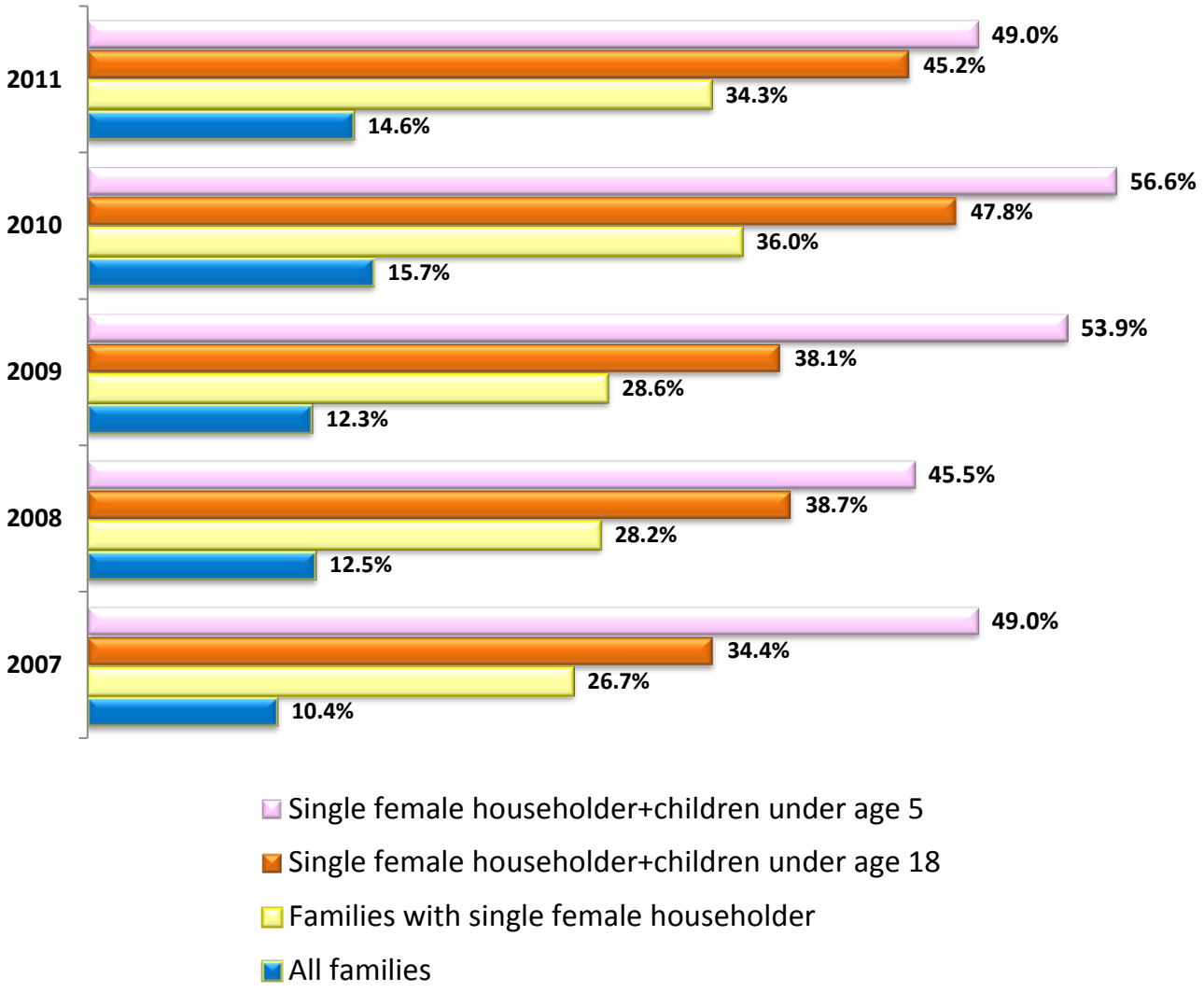


Source: U. S. Census Bureau (2007, 2008, 2009, 2010, 2011 American Community Surveys)

Chart 14 shows the percentage of families in poverty, by type of family structure to demonstrate how the type of household is related to the rate of poverty. For all five years, the type of households most likely to be in poverty were single female households with children under age 5, followed by single-female households with children under age 18. Because poverty is also connected with decreased academic performance in children and lower lifetime earnings, this has the potential to perpetuate generational poverty.

Single female householders with children under age 5 were more likely to be in poverty, as well as single female householders with children under age 18. The rate of poverty for single female householders with children under age 5 was lower in 2011 than in either 2010 or 2009. A similar trend was not observed for all families, since 2010 and 2011 were higher than 2007-2009. After an increase from 12.4% in 2009 to 15.7% in 2010, there has been a slight decrease for all families to 14.6%.

Chart 14: Percentage of Families in Poverty by Type
Davidson County, 2007-2011



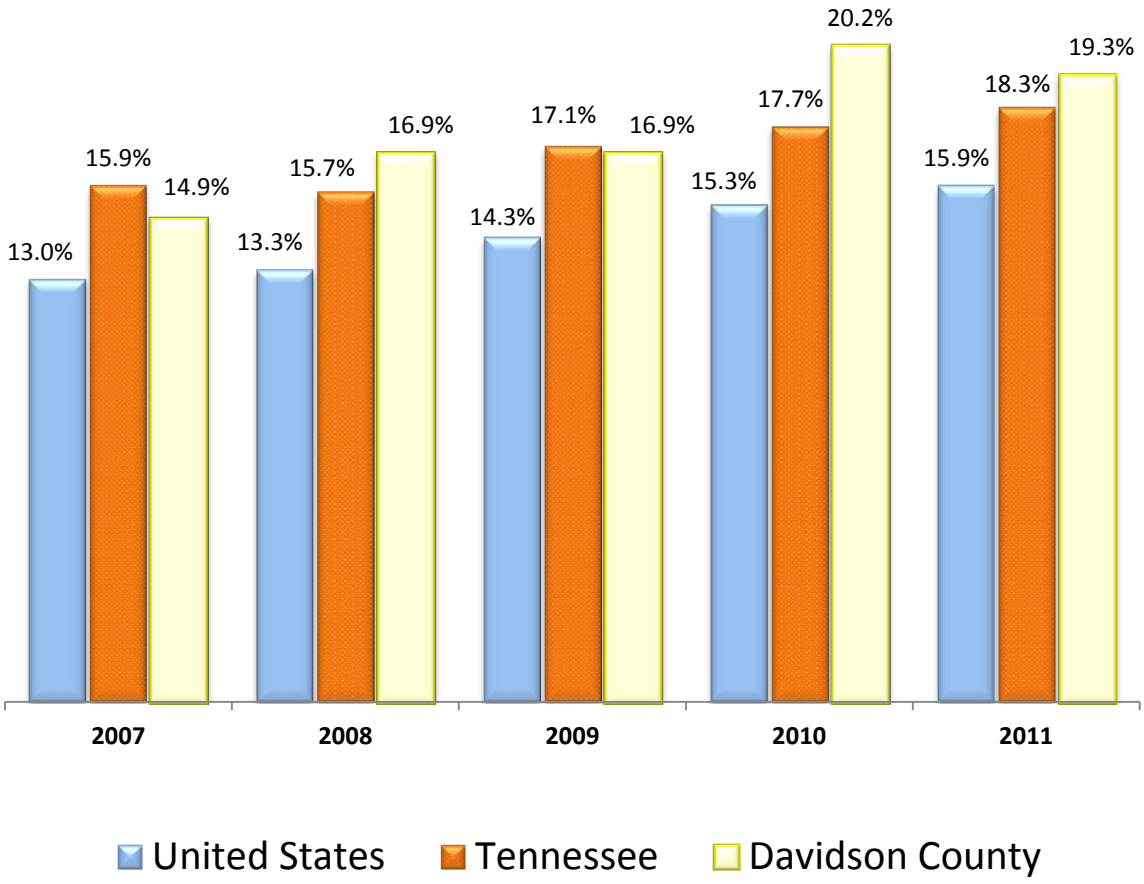
Source: U. S. Census Bureau (2007, 2008, 2009, 2010, 2011 American Community Surveys)

Chart 15 compares the rates of poverty for the U. S., Tennessee and Davidson County from 2007 to 2011. In 2010 and 2011, the Davidson County poverty rate was higher than the poverty rates for both Tennessee and the U.S.

Between 2007 and 2011, the rate of poverty increased more in Davidson County than for either the state or the nation. During that time, the Davidson County poverty rate increased more than the rate for the U. S. and Tennessee.

Chart 15: Percentage of People in Poverty

U. S., Tennessee, Davidson County, 2007-2011



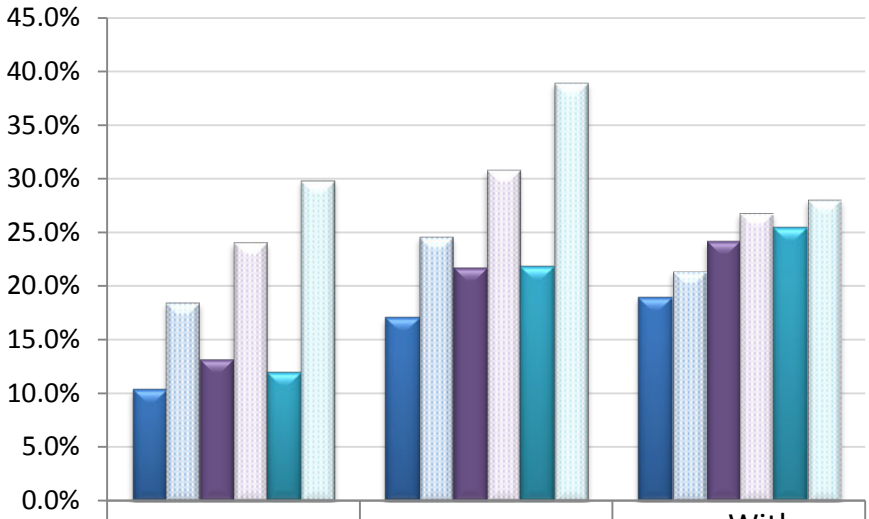
Source: U. S. Census Bureau (2007, 2008, 2009, 2010, 2011 American Community Surveys)

Chart 16 shows that the foreign-born population is more likely to experience poverty in the U. S., Tennessee and Davidson County than those born in the U. S., regardless of the family composition. The poverty rate for foreign-born people in all three family composition categories identified below was higher in Davidson County than in Tennessee or the U. S.

In Davidson County, there are about 8 times as many native-born residents as there are foreign-born residents. However, among all families, the foreign-born families in Davidson County experience poverty at about 2 ½ times the rate of native-born residents.

Chart 16: Poverty Rate By Family Composition in Native/Foreign-Born

U.S., Tennessee, Davidson County, 2011



	All families	With related children under 18 years	With related children under 5 years only
U.S. Native-Born	10.4%	17.1%	19.0%
U.S. Foreign-Born	18.5%	24.6%	21.4%
Tennessee Native-Born	13.2%	21.7%	24.2%
Tennessee Foreign-Born	24.1%	30.8%	26.8%
Davidson Co. Native Born	12.0%	21.9%	25.5%
Davidson Co. Foreign Born	29.9%	39.0%	28.1%

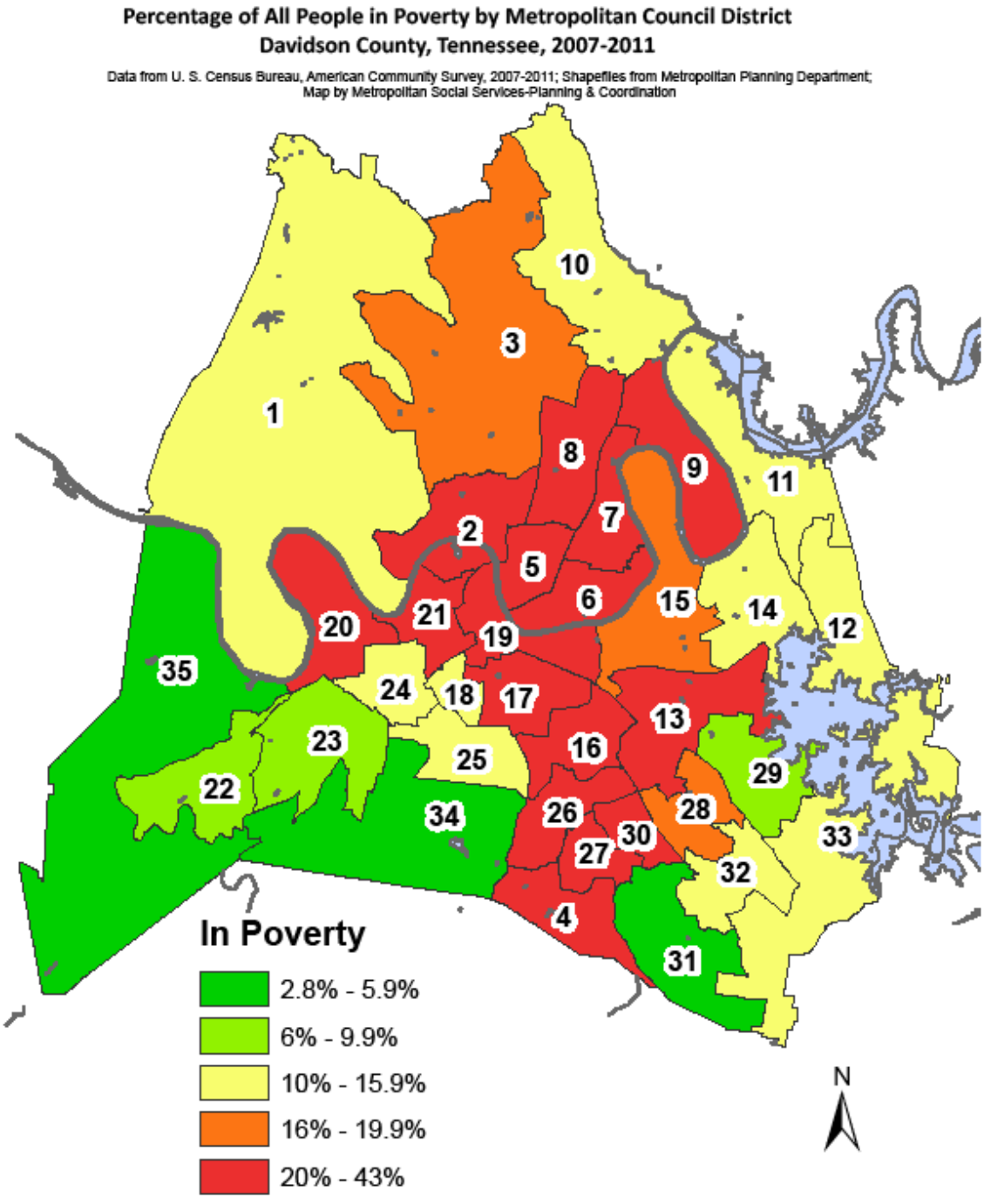
Source: U. S. Census Bureau (2007-2011 American Community Survey)

As shown in the table below, poverty in Davidson County varies by type of family structure and age category. According to the 2007-2011 American Community Survey 5-Year Summary, the poverty rate for All People is highest in Metropolitan Council District 19 at 43.0% and lowest in District 34 at 2.8%. Six Council Districts (17, 19, 21, 6, 2 and 5) have poverty rates over 50% for those who are under age 18.

The most significant disparity may be seen in the category most likely to be poor, Female Householders with Children Under Age 5. Five Council Districts (34, 18, 15, 29 and 23) have no Female Householders with Children Under Age 5 in poverty. However, several Council Districts have poverty rates for that category over 60%. A more detailed data profile by Council Districts will be available on the Metropolitan Social Services web site in early 2013.

Percent in Poverty by Metropolitan Council Districts	All Families	Single Female Householder+ Children Under Age 5	All People	Under 18 Years	18 to 64 Years	65 Years and Over
District 1	7.1%	8.5%	11.0%	26.0%	8.0%	4.1%
District 2	28.3%	77.6%	33.5%	52.7%	26.8%	24.0%
District 3	15.6%	26.9%	19.5%	32.8%	16.0%	9.8%
District 4	17.1%	74.6%	21.7%	36.7%	19.8%	10.5%
District 5	31.6%	64.3%	34.6%	51.6%	30.3%	9.1%
District 6	29.4%	95.0%	32.2%	57.6%	24.5%	21.7%
District 7	14.7%	34.4%	20.0%	24.0%	19.9%	13.5%
District 8	19.6%	77.7%	23.0%	38.7%	19.3%	14.7%
District 9	19.9%	33.8%	25.9%	32.4%	24.7%	19.6%
District 10	7.7%	14.8%	11.0%	17.8%	10.0%	6.0%
District 11	6.3%	7.0%	10.6%	6.0%	12.4%	9.2%
District 12	9.9%	29.5%	13.2%	24.0%	10.3%	5.8%
District 13	18.9%	58.6%	20.8%	35.5%	17.2%	4.0%
District 14	10.3%	100.0%	13.3%	18.4%	13.0%	5.9%
District 15	12.3%	33.0%	16.8%	30.7%	14.4%	8.4%
District 16	20.3%	51.6%	25.5%	38.7%	24.0%	7.6%
District 17	32.7%	81.9%	39.2%	69.2%	31.9%	22.1%
District 18	2.6%	0.0%	11.7%	0.8%	13.5%	13.5%
District 19	37.7%	100.0%	43.0%	68.9%	36.0%	32.7%
District 20	18.8%	51.8%	22.6%	39.4%	18.9%	11.7%
District 21	35.5%	50.0%	36.6%	60.4%	30.0%	25.0%
District 22	8.2%	12.4%	8.7%	7.5%	9.4%	6.9%
District 23	2.9%	0.0%	7.2%	10.3%	7.3%	2.1%
District 24	11.1%	69.0%	15.0%	28.8%	12.3%	11.2%
District 25	2.0%	-	10.0%	1.6%	12.9%	3.5%
District 26	16.0%	18.4%	22.2%	41.7%	17.4%	8.9%
District 27	20.5%	82.5%	24.8%	43.8%	20.4%	8.0%
District 28	15.8%	37.2%	18.9%	30.2%	15.2%	4.1%
District 29	4.5%	0.0%	9.3%	10.0%	9.4%	5.8%
District 30	18.7%	62.0%	22.8%	31.9%	20.3%	11.4%
District 31	3.9%	11.0%	5.9%	11.8%	4.7%	1.8%
District 32	9.5%	36.6%	11.4%	15.1%	10.4%	2.3%
District 33	10.3%	50.5%	11.0%	15.9%	9.3%	14.5%
District 34	1.4%	0.0%	2.8%	0.4%	3.5%	3.5%
District 35	2.8%	100.0%	4.3%	3.2%	5.0%	3.0%

This map below shows the percentage of all people in poverty. The sections shown in **orange** and **red** are above the U. S. poverty rate.



Grassroots Community Survey

The survey instrument in 2009 and 2010 included the issues of Food and Nutrition, Housing and Related Assistance, Workforce and Economic Opportunity, Home and Community Services and Transportation. The need categories were expanded for 2011 and 2012 and are reflected in the charts below.

During all four years in which the Grassroots Community Survey has been conducted, the two most highly ranked gaps between available services and needs were for ***Housing and Related Assistance*** *and* ***Workforce & Economic Opportunity****. This is especially noteworthy because each year, the surveys were conducted in different venues.*

For all needs, it is important to consider the long-term implications of unmet needs as well as the necessity of using demographic projections to plan for emerging trends. Due to the interrelatedness of the identified needs, those not at the top may still be important for addressing service gaps and addressing unmet needs.

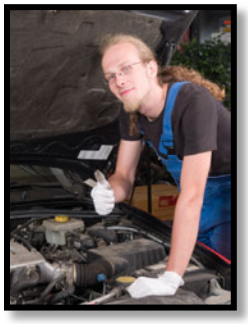
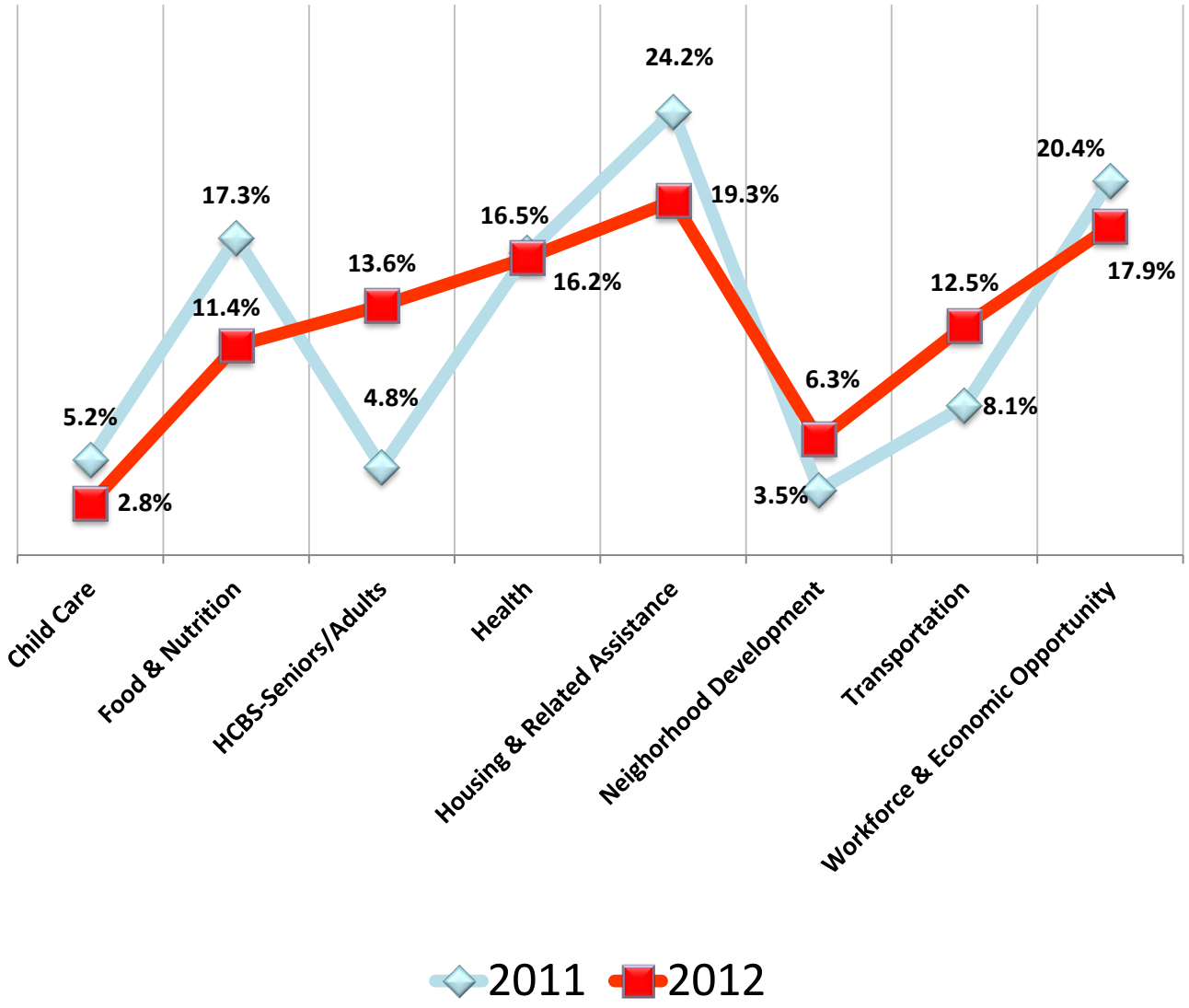


Chart 17 shows that in both 2011 and 2012, the respondents more frequently identified Housing and Related Assistance than other needs, followed closely by Workforce and Economic Opportunity. The chart compares the 2011 and 2012 responses about the greatest gaps in needs. In both years, the greatest gap was identified as Housing and Related Assistance, followed by Workforce and Economic Opportunity.

In both years, Child Care and Neighborhood Development were least frequently identified as the greatest gap. Home and Community Based Services-Seniors/Adults increased from 4.8% to 13.6%, possibly due to the aging population or the level of awareness about aging patterns and increased needs. Although Transportation is still ranked 5th out of the 8 needs, there was an increase from 8.1% to 12.5% in the rate of identification as the greatest gap in services.

Chart 17: Greatest Gap in Need by Category

Grassroots Community Survey, 2011-2012



2-1-1 Call Center
United Way of Metropolitan Nashville

United Way of Metropolitan Nashville's 2-1-1 Call Center, operated through a partnership with Family & Children's Service, provides a central location with information about how to receive assistance with community, health and social services. Davidson County has a complex system of service delivery with many public and private service organizations, and 2-1-1 is an important tool to help people who need assistance find what they need.

The 2-1-1 Call Center provides services in multiple languages, with services provided by experts who are nationally certified Information & Referral Specialists. Both individuals and agency professionals use 2-1-1 as an effective way to identify specific resources to help those in need. 2-1-1 provides callers with information about resources to meet their social/human service needs. Some people also call to offer donations or other help to those in need. In addition, many organizations also use the online version of 2-1-1.
www.211tn.org

The 2-1-1 Call Center began in 2004 and has accumulated a great deal of data to show the trends in needs for 2-1-1 callers. While 2-1-1 is the primary information and referral line in Nashville, there are others related to specific populations (Disability Pathfinders, Aging and Disability Resource Connection, etc.).

Davidson County's 2-1-1 has assisted thousands of callers and maintains a referral database with information on more than 2000 service providers Davidson County and nearby areas. The data is not a random sample of needs and does not include calls from people who contact agencies directly, but it is an important component in demonstrating needs in the community.

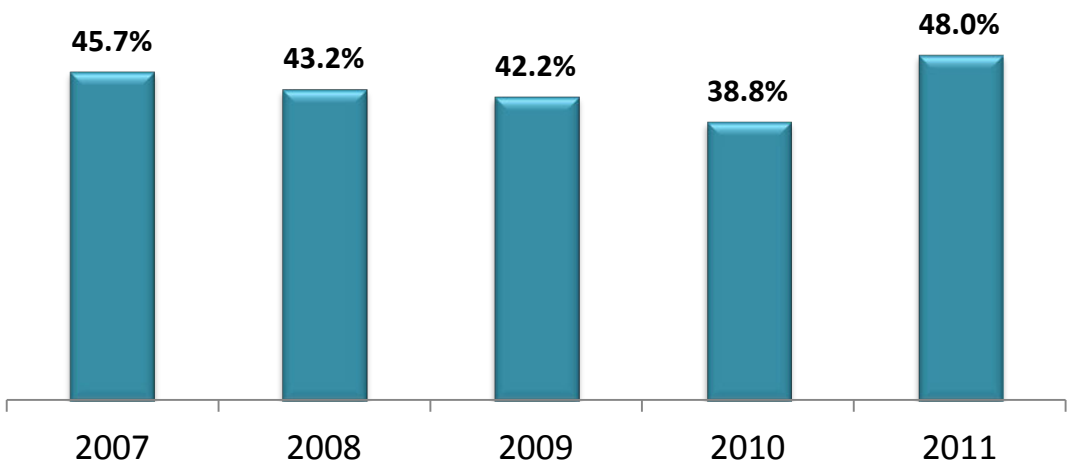
Because of the complexity of the service delivery system, it is important to categorize the numerous services available to the community, and most call centers use similar categories.

Category	Definition
Arts, Culture and Recreation	Camps/summer camps, physical fitness, parks
Clothing/Personal/Household Needs	Furniture, clothing, cell phones, fans/AC, diapers, appliances
Disaster Services	Disaster relief/recovery organizations, FEMA, preparedness
Education	GED, adult education, school districts, Head Start, Vocational
Employment	Career centers, career development, Workforce Investment Act programs, job search
Food/Meals	Food pantries, food stamps, meals on wheels, women/infants/children
Health Care	Dental care, prescriptions, sliding scale clinics, health insurance, glasses

Housing/Utilities	Utility payment, rent payment, shelter, subsidized housing, domestic violence shelter
Income Support/Assistance	VITA, unemployment, social security, Medicaid, SSI, credit counseling
Individual, Family and Community Support	Case management, children's protective services, animal control, adult protective services
Information Services	Other 211's, directory assistance, 311, specialized I&R, government hotlines
Legal, Consumer and Public Safety Services	Legal services, child support, police, driver's license
Mental Health/Addictions	Crisis intervention, domestic violence hotlines, counseling, substance abuse, mental health facilities
Other Government/Economic Services	Waste management, streets, building safety, public works
Transportation	Gas money, medical appointment transportation, traveler's aid, greyhound
Volunteers/Donations	Donation pickups, volunteer opportunities

In an analysis of the previous five years of calls, 2-1-1 has identified calls for an average of 135,883 needs each year, making 214,365 annual referrals during that time period. Many of the calls to 2-1-1 are for basic needs (Food, Housing/Utilities). As shown in Chart 18, calls for basic needs increased to 48.0% in 2011, the highest percentage during the past 5 years.

Chart 18: 2-1-1 Calls, Percent of Basic Need Calls
2007, 2011



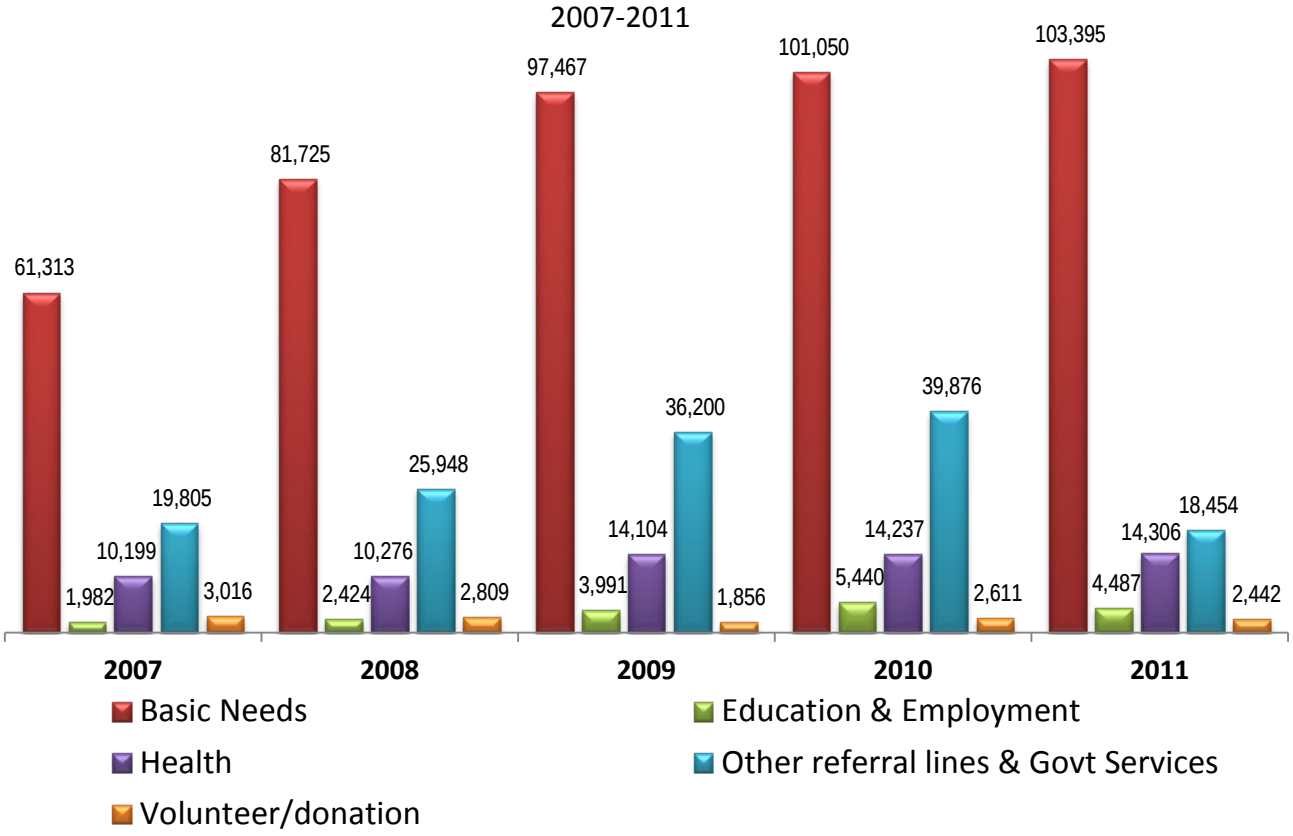
Source: United Way of Metropolitan Nashville

Chart 19 shows the number of calls to 2-1-1 categorized by Basic Needs, Health, Volunteer/Donation, Education & Employment and Other Referral Lines & Government Services. The chart shows a pattern

of increase in the number of Basic Needs and Health calls over the past 5 years, with variation across the other categories.

Chart 19: Calls to 2-1-1 By Category

2007-2011

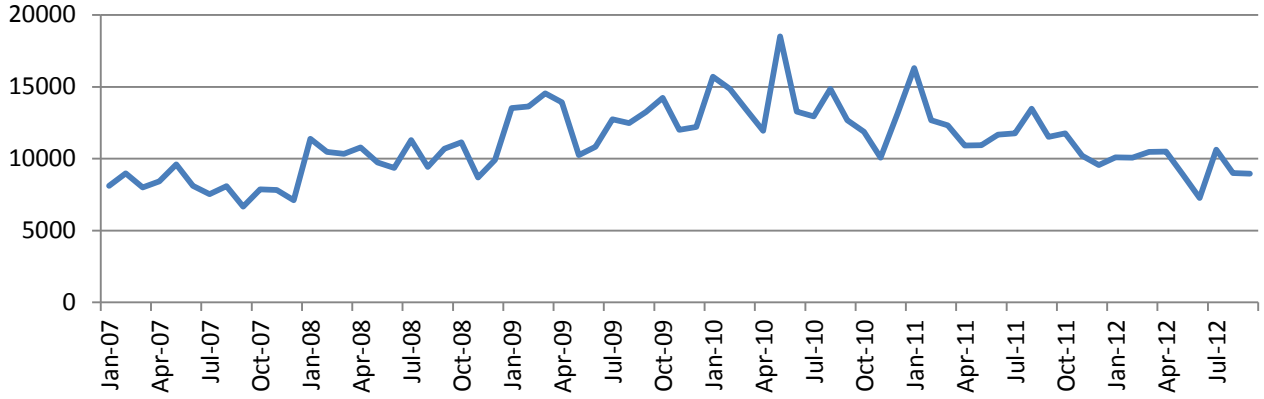


Source: United Way of Metropolitan Nashville

Chart 20 shows a variation in the number of needs identified in 2-1-1 calls by month, which peaked around the time of the May 2010 flood.

Chart 20: Total Needs Identified from 2-1-1 Calls by Month

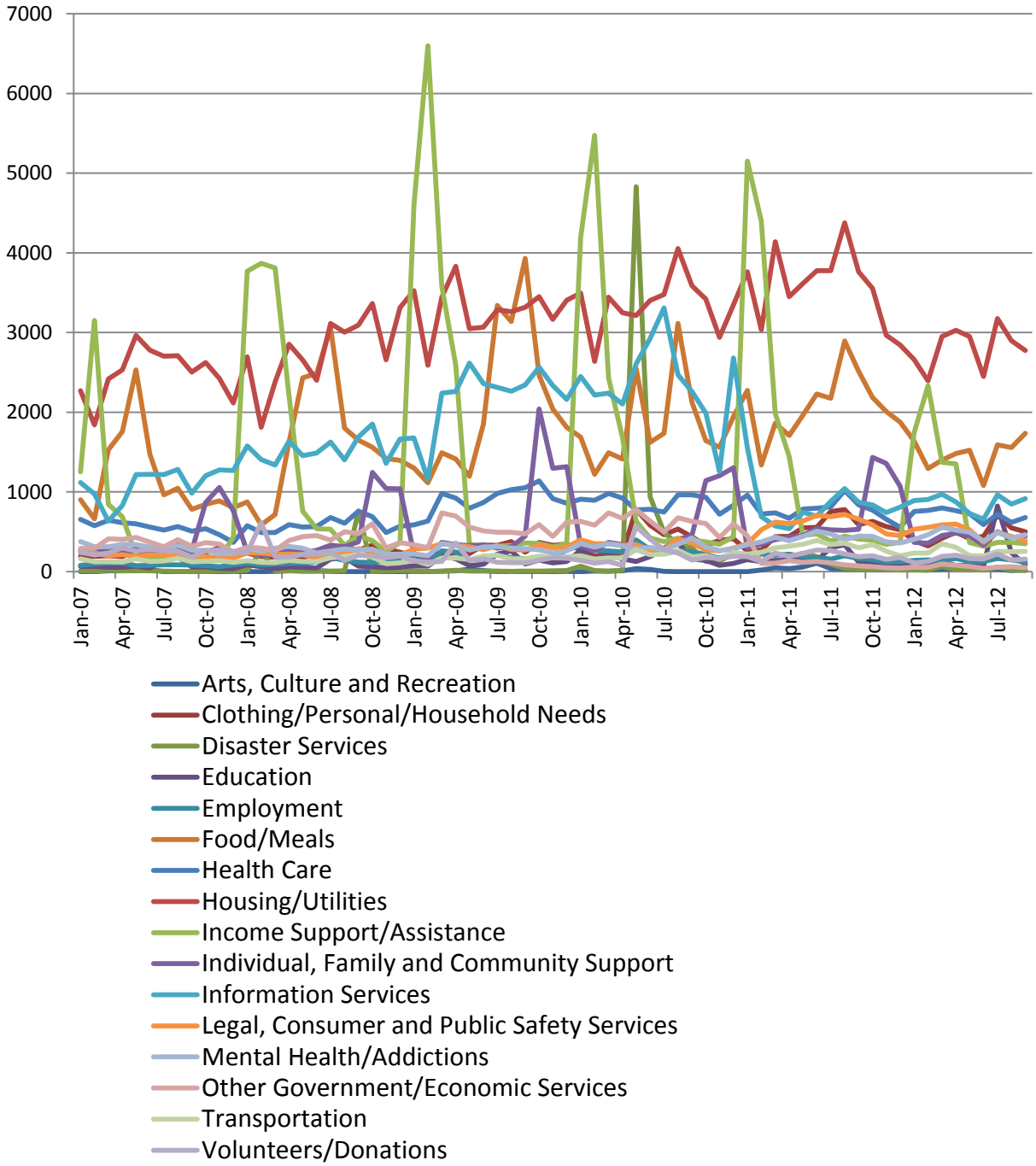
January 2007-July 2012



Source: United Way of Metropolitan Nashville

As shown in Chart 21, United Way's 2-1-1 Call Center receives calls about a wide array of social and human service needs. It shows a consistently high number of calls for Housing/Utilities, with a large number of calls for Income Support/Assistance with higher spikes especially during the recession.

Chart 21: Calls to 2-1-1 by Category
January 2007-July 2012



Source: United Way of Metropolitan Nashville

Characteristics of Poverty

As explained in previous Community Needs Evaluations, poverty is not simply the lack of income or a shortage of material goods. Human poverty can also mean a loss of dignity, a sense of powerlessness, perception of being marginalized or excluded. This deprivation can diminish aspirations and achievements, particularly for the poor children who are well aware of what they are missing.

> **"Homelessness, poor health, hunger—poverty's consequences can be severe. Growing up in poverty can harm children's well-being and development and limit their opportunities and academic success. And poverty imposes huge costs on society through lost productivity and higher spending on health care and incarceration."** (Urban Institute) *Consequences of Poverty*)

U. S. poverty thresholds are based on calculations based on the number and age of people in the household or family and pre-tax income. The Census Bureau defines poverty for an individual under age 65 as income lower than $11,702 and for age 65 and over as $10,788. There are incremental increases for each additional person in the household, up to $43,487 for 9 people including 8 children. Below is a section of the poverty threshold table.

	With No Children	One Child	Two Children	Three Children	Four Children
One person (unrelated individual)					
Under 65 years	$ 11,702				
65 years and over	$ 10,788				
Two people					
Householder under 65 years	$ 15,063	$ 15,504			
Householder 65 years and over	$ 13,596	$ 15,446			
Three people	$ 17,595	$ 18,106	$ 18,123		
Four people	$ 23,201	$ 23,581	$ 22,811	$ 22,891	
Five people	$ 27,979	$ 28,386	$ 27,517	$ 26,844	$ 26,434

https://www.census.gov/hhes/www/poverty/data/threshld/index.html

Additional Information about poverty definitions, income distribution, poverty projections, deaths related to social factors and poverty reduction/alleviation efforts is included in the 2011 Community Needs Evaluation (please refer to pages 19-40).

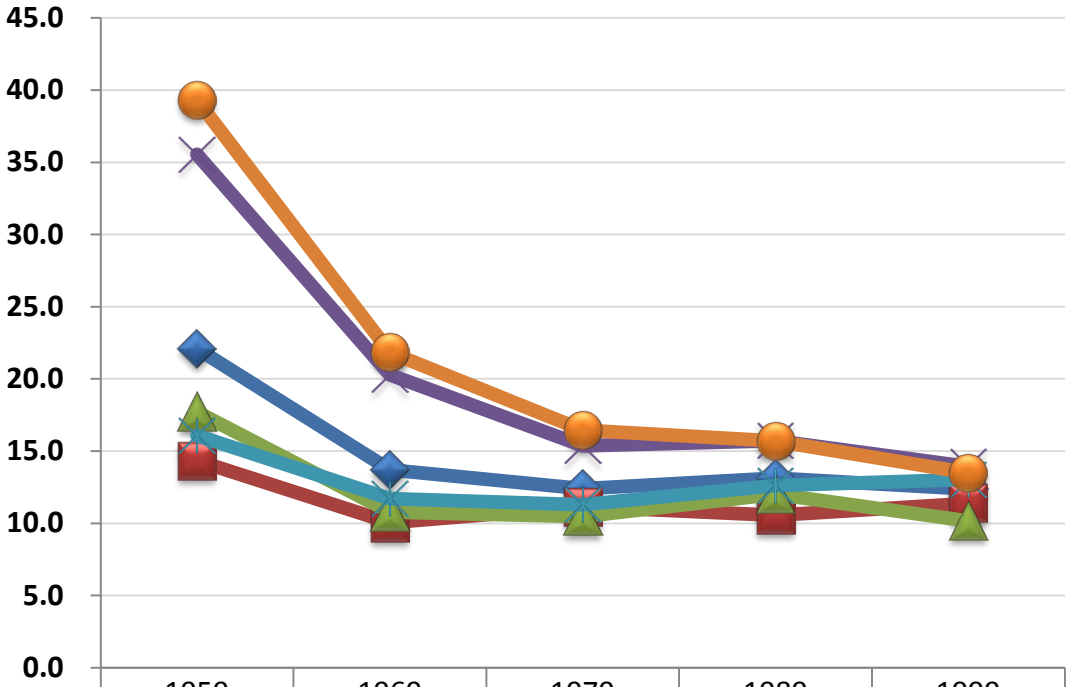
Historical Poverty Rates

Chart 22 shows the historical trends for about the last 50 years for the U. S., Tennessee and Davidson County. Tennessee and its inclusive region, the South, experienced poverty rates that were significantly higher than other regions 40-50 years ago. It is likely that the dramatic reduction that occurred before the end of the 1960's may have been related to the array of national anti-poverty programs that began around that time.

It is noteworthy that from 1959 to 1999 showed a trend toward consistency in the rate of poverty across Tennessee, all regions and the U.S. In 1959, Tennessee's poverty rate was almost twice that of the U. S., and the South region's poverty rate was more than twice the rates for all of the other regions. By 1999, the poverty rate for Tennessee and the South was much closer to the poverty rate for the U. S. and other regions.

Chart 22: Percentage in Poverty by Region (Historical)

U. S./Regions/Tennessee, 1959, 1969, 1979, 1989, 1999



	1959	1969	1979	1989	1999
United States	22.1	13.7	12.4	13.1	12.4
Northeast	14.4	10.1	11.2	10.6	11.4
Midwest	17.7	10.8	10.5	12.0	10.2
South	35.6	20.3	15.4	15.7	13.9
West	16.1	11.7	11.3	12.6	13.0
Tennessee	39.3	21.8	16.5	15.7	13.5

Source: U.S. Census Bureau (CPH-L-162)

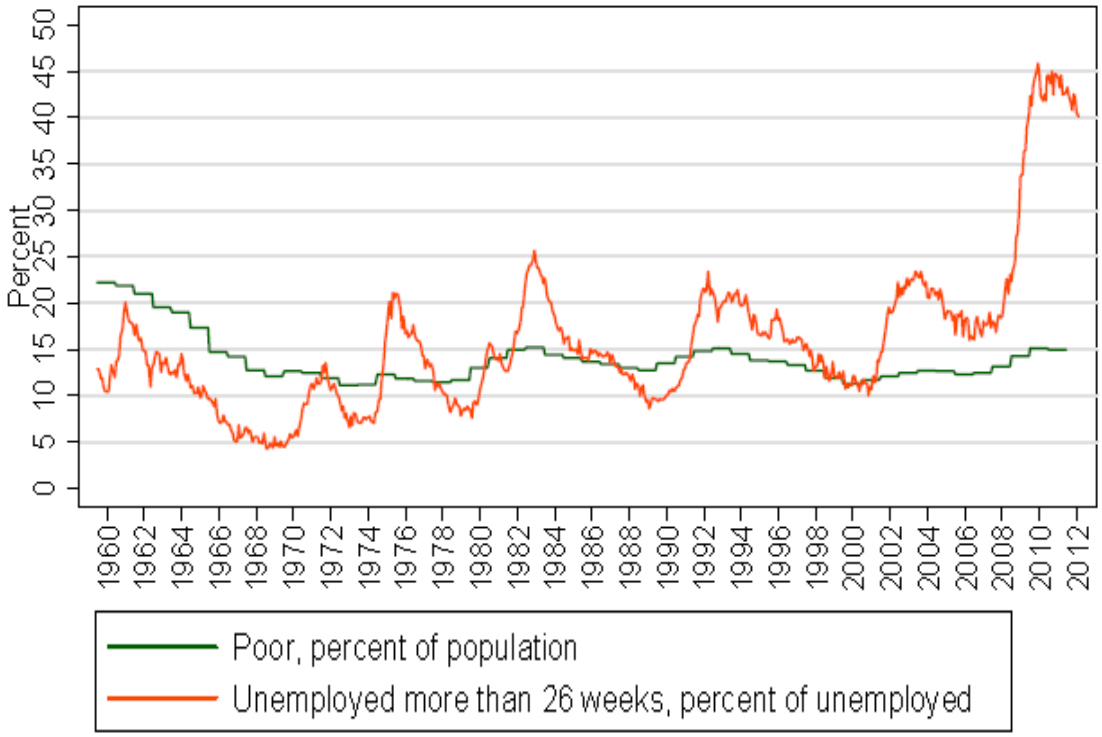
Relationship of Poverty and Unemployment

During the past 50 years, poverty and unemployment have been closely connected. As described in The Urban Institute's *Poverty in the United States* in September of 2012, there are reasons the poverty rate is nowhere near the extreme rates of the 1960's. Part of the difference can be attributed to the federally funded programs developed since that time, including Social Security benefits and unemployment benefits.

Chart 23 shows that even though the rate of unemployment for more than 20 weeks was higher in recent years than it has been at any time since 1960, the poverty rate was far lower than the 1960s. The report also notes that poverty remained higher for some groups (children, minorities, single-parent families) than for others.

Chart 23: Poverty and Employment Duration Rates

U. S., 1960-2012



Source: Urban Institute-Unemployment and Recovery Project
http://www.urban.org/UploadedPDF/412653-Poverty-in-the-United-States.pdf

Asset Poverty

While poverty relates to the amount of income and number of people, asset poverty increased for many as their accumulated wealth drastically declined during the recession. As explained by the Urban Institute's *U. S. Asset Poverty and the Great Recession* in October 2012, a family is asset poor "if it does not have enough resources, measured as total wealth (net worth), to live at the federal poverty level for three months." That would be the equivalent of $5,580 for a family of four.

Even before the recession, asset poverty rates were already much higher for minority families. The *Asset Poverty* report notes that in 2010, black non-Hispanic families and Hispanic families were twice as likely to be poor as white non-Hispanics. It also discusses how age affects the asset poverty rate, with the highest rate for those ages 30-39. Those under age 30 were more likely to already be poor, so they had less to lose.
http://www.urban.org/publications/412692.html

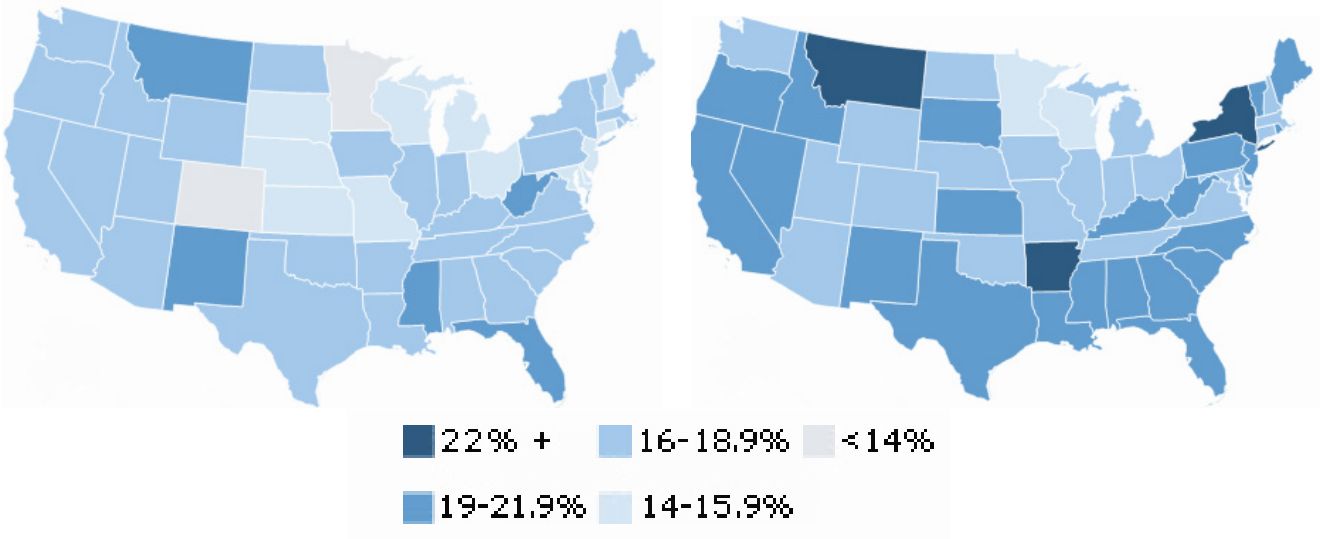
Economic Security

The Economic Security Index (ESI) was developed through the Institution for Social and Policy Studies at Yale University, with support from the Rockefeller Foundation. It provides a measure of economic security in the U. S. Rather than be a measure of income alone, if focuses on what has been lost in terms of a decrease in income and/or large out-of-pocket medical spending, for those who lack adequate financial resources to compensate for the lost income until recovery to the former level of income.

ESI specifically considers:

- Major income loss and or out-of-pocket medical costs, with at least a 25% change from the previous year.
- Insufficient liquid financial assets to replace the lost income until the income level increases to its former level.

In June 2012, the Economic Security Index's report, *Economic Insecurity Across the American States,* described the detrimental effect of the Great Recession by states. The maps below show the increasing level of economic insecurity. The map on the left below shows Economic Security by state in 2000, compared with the map on the right showing 2011.



Economic Insecurity Across the American States reported that from 2008-2010, only 12 states had higher levels of insecurity (based on the prevalence of large economic losses), with Tennessee ranking 21.6% for economic insecurity, compared to 20.3% for the U. S. The Great Recession negatively affected economic security for all states, although there were variations from state to state.

Although this is a different type of measure than poverty, there are some correlations with key demographic and economic characteristics across states. As expected, economic insecurity is related to higher rates of poverty/unemployment and lower levels of education. Despite this, the research noted that some states have higher levels of economic insecurity (Mississippi, Arkansas) or lower levels of economic insecurity (Michigan, Utah) than would be expected based on the rates of poverty.
http://economicsecurityindex.org/

According to the Corporation for Enterprise Development (CFED), liquid asset poverty rate is the percentage of households without sufficient liquid assets to subsist at the poverty level for three months in the absence of income. Liquid assets are those that are held in cash or can be liquidated immediately.

According to CFED, having emergency savings can prevent financial setbacks, and families without emergency savings are much more likely to suffer hardships in the event of economic emergency, such as losing a job. In 2012, a family of four with liquid assets less than $5,763 is liquid asset poor. CFED just released its 2013 Assets and Opportunity Scorecard, which is a State-by-State assessment of how well residents are faring in terms of wealth, poverty, and financial security. According to the scorecard, 43.9% of United States households are considered "liquid asset poor," meaning they lack the savings to cover basic expenses for three months if unemployment, a medical emergency or other crisis leads to a loss of a stable income. In Tennessee, 53.7% of households are liquid asset poor.
http://scorecard.assetsandopportunity.org/2012/measure/liquid-asset-poverty-rate

Child Poverty

The Urban Institute's *Child Poverty and Its Lasting Consequence* described research findings about the significant and persistent effects of poverty on children. It indicated that poverty is more likely to be persistent for a child born to parents with a low level of education. It noted that children who were poor from birth to age 2 were 30% less likely to finish high school than children who become poor when they were older. Children who were persistently poor were 90% more likely in their 20s to have dropped out of high school and 4 times more likely to have had a teen premarital birth. Because a child's early environment can affect brain development, the report emphasized the importance of intervention at birth for low-income, less educated parents, including home visiting and parental counseling.
http://www.urban.org/publications/412659.html

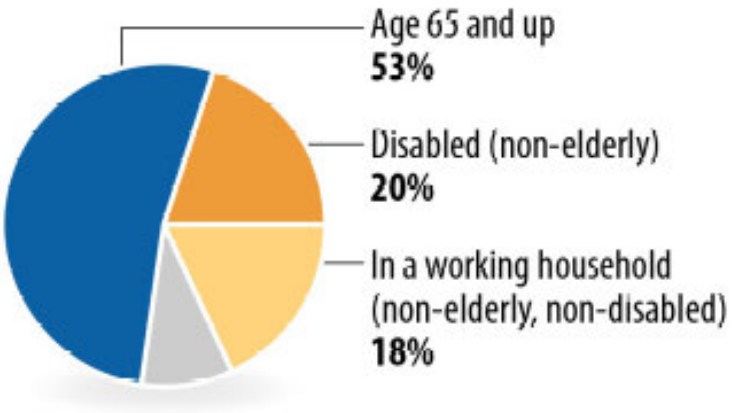
Allocation of Federal Entitlement Programs

In a February 2010 analysis of federal entitlement spending, the Center on Budget and Policy Priorities (CBPP) reviewed data from the U. S. Office of Management and Budget, the U. S. Departments of Agriculture, Health and Human Services, Labor and the Census Bureau. They found that most of the entitlement benefits go to the elderly, with significant proportions going to those with serious disabilities, with lesser amounts to working households or others. (Federal entitlement programs

include Social Security, Medicare, Medicaid, unemployment insurance, SNAP, SSI, TANF, school lunch program, EITC and the refundable component of the Child Tax Credit.)

Chart 24 shows that 53% of federal entitlement benefits go to persons who are over age 65, 20% to persons with disabilities who are under age 65, and 18% to low-income working households, with 9% to others. The CBPP explains this is a typical representation for the proportion for the past few years. It explains that while there is some public perception that entitlement programs support "able-bodied, working-age Americans who choose not to work," the actual budget expenditures do not support that idea.

Chart 24: Federal Entitlement Spending By Category
U. S., 2010



Source: Federal budget data, analyzed by the Center on Budget and Policy Priorities

As a result, 73% of the federal entitlement spending is specifically for people over age 65 and those with serious disabilities. The 9% that has not been otherwise specified is spent on medical care, unemployment insurance benefits, Social Security survivor benefits for children and spouses of deceased workers and Social Security retirement benefits for people ages 62-65.
http://www.cbpp.org/cms/?fa=view&id=3677

In May 2012, the CBPP followed up with an analysis of whether federal programs for low-income persons affected national long-term fiscal problems. This report found two reasons for the growth in income based federal programs – the economic downturn and the rising cost of health care in the U. S. Spending for mandatory entitlement programs (excluding health care) has averaged 1.3% of the Gross Domestic Product for the past 40 years. While it rose to 2.0% by the end of the recession, it is expected to drop to its prior 40-year average of 1.3% by 2020.

It explains that the U. S. faces a "serious long-term fiscal problem as a result of a large projected imbalance between revenues and expenditures," with the projected increase in health care costs. Compounding the increase in health care cost will be the additional needs of the aging population that has higher medical costs. The report indicates that will result in a continuing increase in debt, resulting in economic harm and falling living standards.

The CBPP explained that the rapid increase in the utilization of Supplemental Nutrition Assistance Program (SNAP, formerly called Food Stamps) resulted from the recession. Many more low-income households were eligible, partially because of the increased unemployment. However, the increase in SNAP utilization is higher than can be explained by the recession. As the economy recovers and as unemployment continues to decrease, SNAP rates are expected to decrease gradually as a percentage of the GDP by 2018.
http://www.cbpp.org/cms/?fa=view&id=3772

In October 2012, the CBPP's *Social Security Keeps 21 Million Americans Out of Poverty* shows that without Social Security benefits, the poverty rate for seniors would significantly increase. (This is also supported by the data in the U. S. Census Bureau's Supplemental Poverty Measure.)

Nationwide, children and families are helped by Social Security (through the benefits to children as dependents of retired, disabled or deceased workers, as well as those whose parents or other relatives receive benefits). It reports that in addition to keeping 21 million seniors out of poverty, Social Security benefits also keep more than 1 million children out of poverty.

As of December 2012, Tennessee has 1,287,683 Social Security Beneficiaries, including 827,555 over age 65, 374,766 from 18-64 and 85,362 under age 18. With Social Security benefits, 11.5% are in poverty, which would increase to 54.8% without Social Security benefits. About 361,000 Tennesseans have been lifted out of poverty by Social Security benefits.
http://www.cbpp.org/cms/index.cfm?fa=view&id=3851



Alternative Measures of Poverty

In addition to the official poverty measure that is currently used to determine eligibility for federal programs, there are other ways to examine poverty that use factors in addition to pre-tax income and size of family/household. The U. S. Census Bureau developed a Supplemental Poverty Measure, used for research but not eligibility, which considers additional factors of in-kind benefits and necessary expenditures. The Social Science Research Council created the Measure of America project that considers factors in addition to income to assess the quality of life.

Supplemental Poverty Measure

It may be difficult to understand the effects of poverty without acknowledging the weaknesses in the official poverty measure, which is used to determine eligibility for government programs. With the *2011 Research Supplemental Poverty Measure-Current Population Report* (November 2012), the U. S. Census Bureau uses a more comprehensive approach that reflects the effects of in-kind government benefits and necessary expenditures. The official poverty measure considers only the pre-tax cash income and number in the household, but does not consider the effect of other economic factors. http://www.census.gov/hhes/povmeas/methodology/supplemental/research/Short_ResearchSPM2011.pdf

The supplemental poverty measure considers these resources in addition to the pre-tax cash income:

- Supplemental Nutritional Assistance (SNAP/Food Stamps)
- School Lunch Program
- Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Housing Subsidies
- Low-Income Home Energy Assistance (LIHEAP)

In determining the supplemental poverty rate, these necessary expenses are deducted (although they are not considered in the official poverty rate):

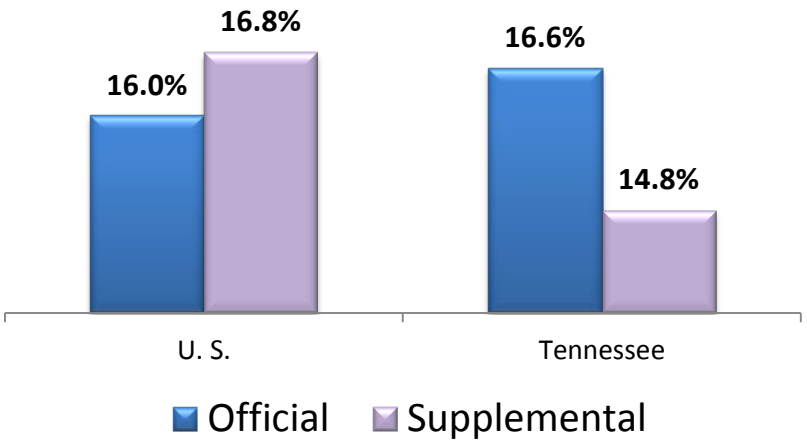
- Taxes
- Work-Related Expenses (transportation, and other expenses related to employment)
- Child Care Expenses
- Medical Out-of-Pocket Expenses
- Child Support Paid

Although the Supplemental Poverty Measure considers additional factors, neither the current nor the supplemental measures consider the amount of available assets. These assets could be used to meet basic needs and families with more assets are better off than those who lack assets. However, “assets can only ameliorate poverty temporarily.” Similarly, accumulated debts are not considered in either measure, although large debts make families more vulnerable to financial crises. Although the cost of housing and other necessities varies significantly by geographic location, neither measure considers where the household is located or the cost of living in that area.

Some states have higher official poverty rates than supplemental rates. In Mississippi, New Mexico and West Virginia, the official poverty rate is at least 4% higher than the supplemental measure. As shown in Chart 25, the supplemental rate is slightly higher for the U.S., while the supplemental rate is almost 2% less in Tennessee as shown in Chart #. States in which there are typically higher official poverty rates (Alabama, Arkansas, Mississippi, North Carolina and Tennessee) all have lower supplemental rates, possibly because the higher utilization of government benefit programs. On the other hand, a number of states had noticeably higher supplemental rates than official rates, including Florida, California, Hawaii, Nevada and the District of Columbia.

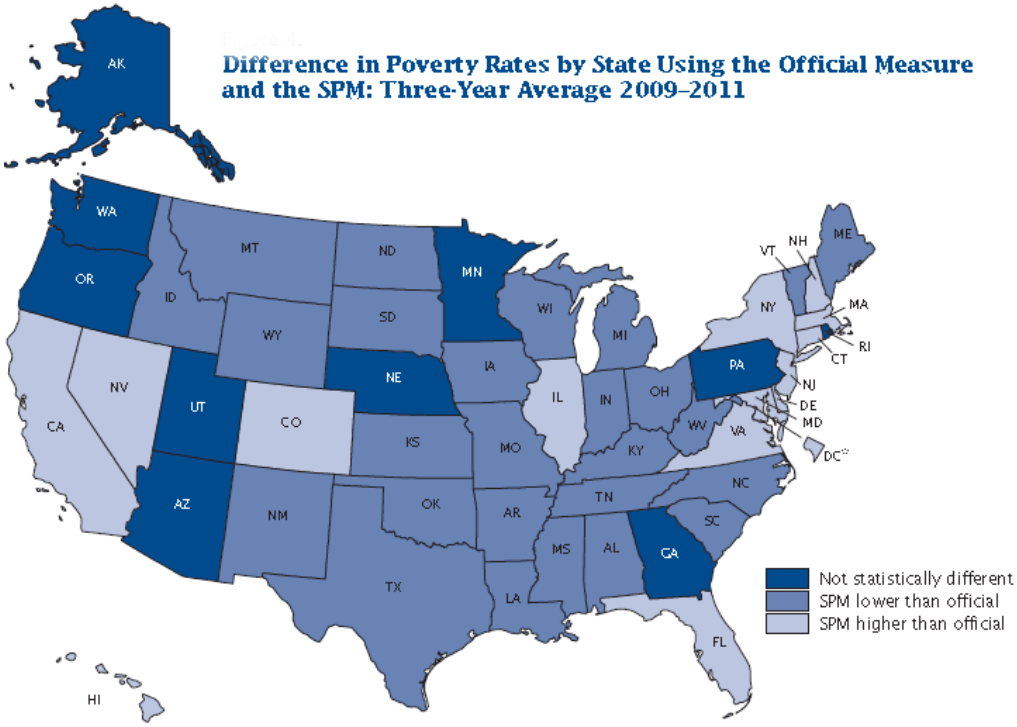
Chart 25: Poverty Rate, Official and Supplemental

U. S., Tennessee, 2009-2011



Source: 2011 Research Supplemental Poverty Measure-Current Population Report, November 2012

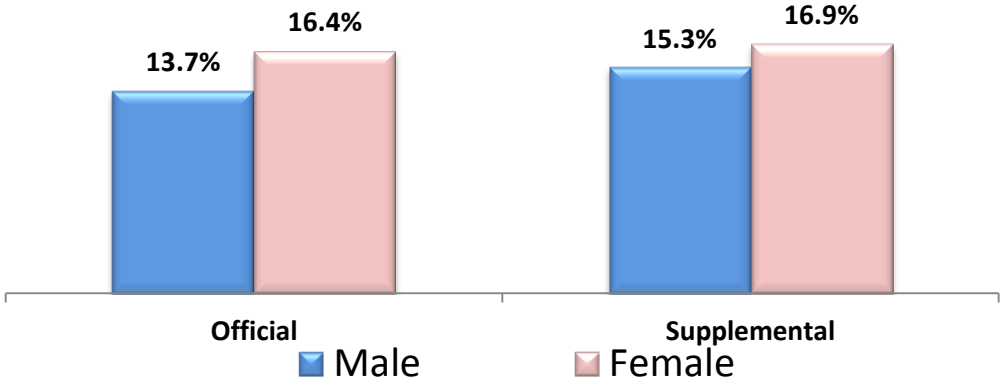
The map shows a comparison of the official and supplemental measures, and shows that in 10 states there was no statistically significant difference.



Source: 2011 Research Supplemental Poverty Measure-Current Population Report, November 2012

Chart 26 compares the official and supplemental rates of poverty in the U. S. by gender. Females experience higher rates of poverty than males, possibly because there are more single-mother households than single-father households. For males, the supplemental measure is higher than the poverty rate, which could have been affected by several factors (deduction in child support paid, work expenses, etc.).

Chart 26: Rate of Poverty, Official and Supplemental by Gender
U.S., 2011

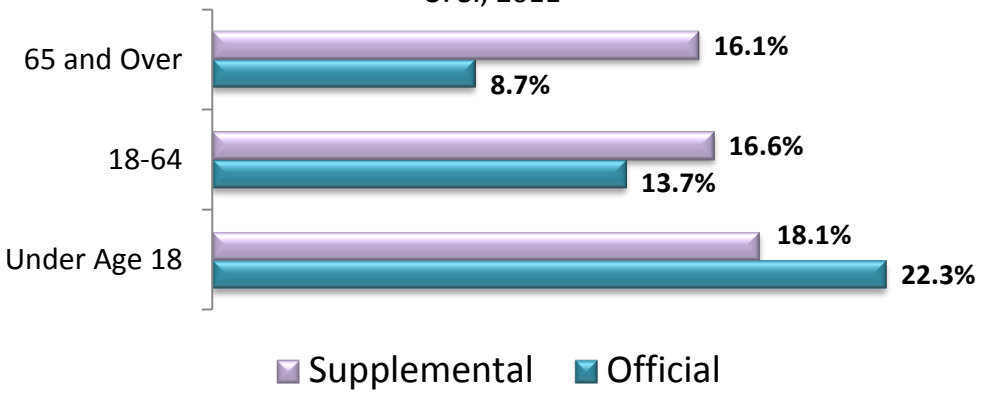


Source: 2011 Research Supplemental Poverty Measure-Current Population Report, November 2012

Several factors in the supplemental poverty measure could contribute to the differences from the official measure for different age categories, shown in Chart 27. For example:

- The supplemental rate of poverty for those 65 and over is almost twice as high as the official measure, which is likely due to the higher level of out-of-pocket medical expenses.
- The supplemental rate is higher for the working age population of 18-64, which could be attributed to the consideration of work related expenses (transportation), child care, etc.
- The supplemental measure for those under age 18 is lower than the official measure, possibly due to the federally funded programs that serve children and their families (SNAP, WIC, free/reduced cost school lunches).

Chart 27: Rate of Poverty, Official and Supplemental by Age
U. S., 2011



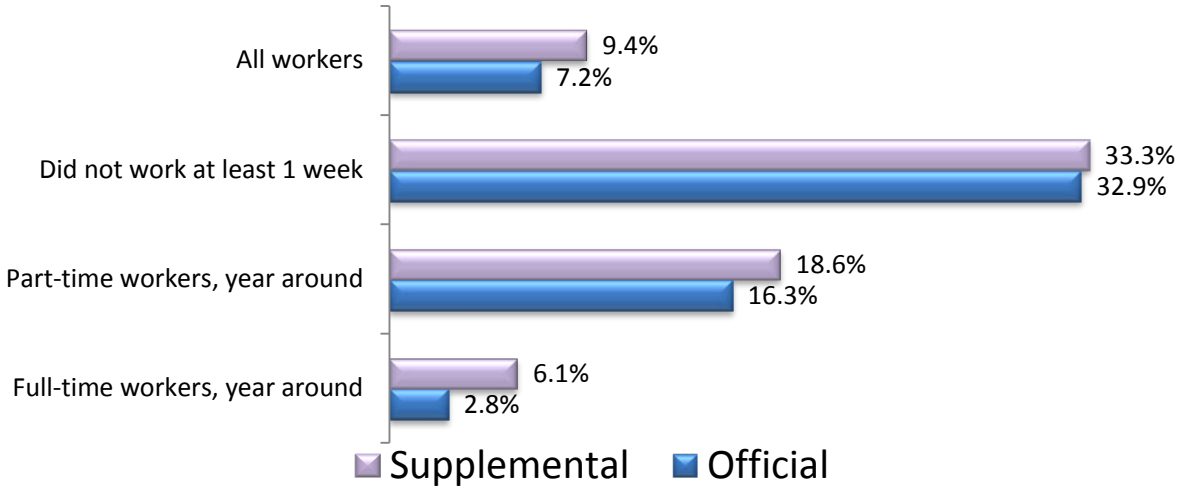
Source: 2011 Research Supplemental Poverty Measure-Current Population Report, November 2012

As shown in Chart 28, the rate of poverty using both measures is far higher among those who did not work at least 1 week during the year. For full-time workers, the supplemental rate is more than twice

as high as the official rate, possibly because of the consideration of work-related expenses, child care and taxes.

Chart 28: Rate of Poverty, Official and Supplemental by Work Status

U. S., 2011

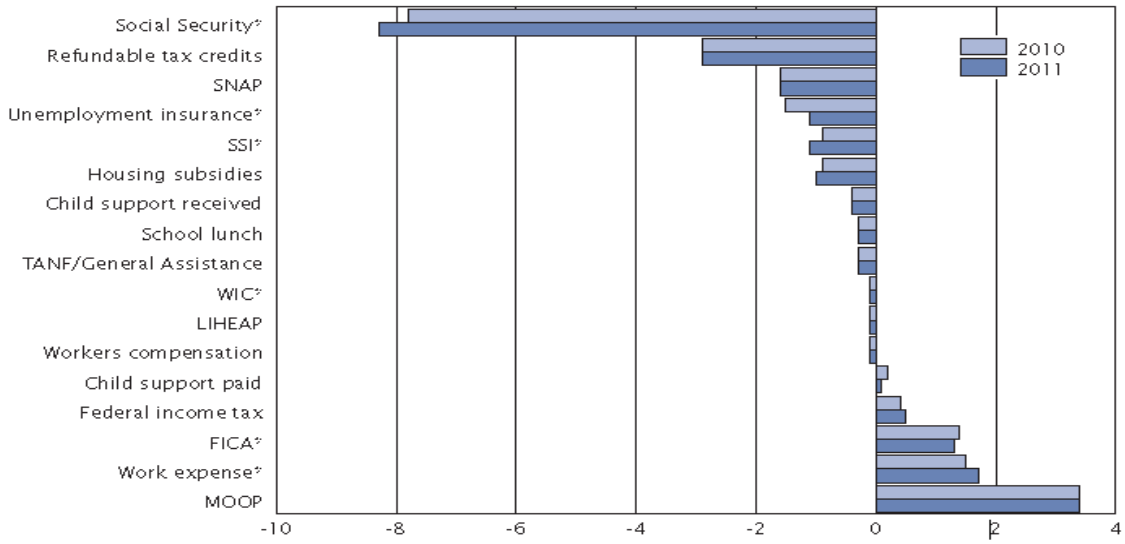


Source: 2011 Research Supplemental Poverty Measure-Current Population Report, November 2012

The supplemental measure also compared changes in various factors, with Chart 29 showing the differences in 2010 and 2011. This shows how taxes, other transfers and necessary expenses affect the supplemental poverty rate by estimating how the elimination of government programs would affect poverty. The most significant impact would be from the elimination of Social Security benefits, which would substantially increase the rate of poverty (for retirees, survivors or children of disabled or deceased workers, etc.). In terms of additional expenditures considered by the supplemental measure, the medical out-of-pocket expenses would affect the rate by more than the other expenses.

Chart 29: Difference in Supplemental Poverty Measure Rates by Element

U. S., 2010-2011

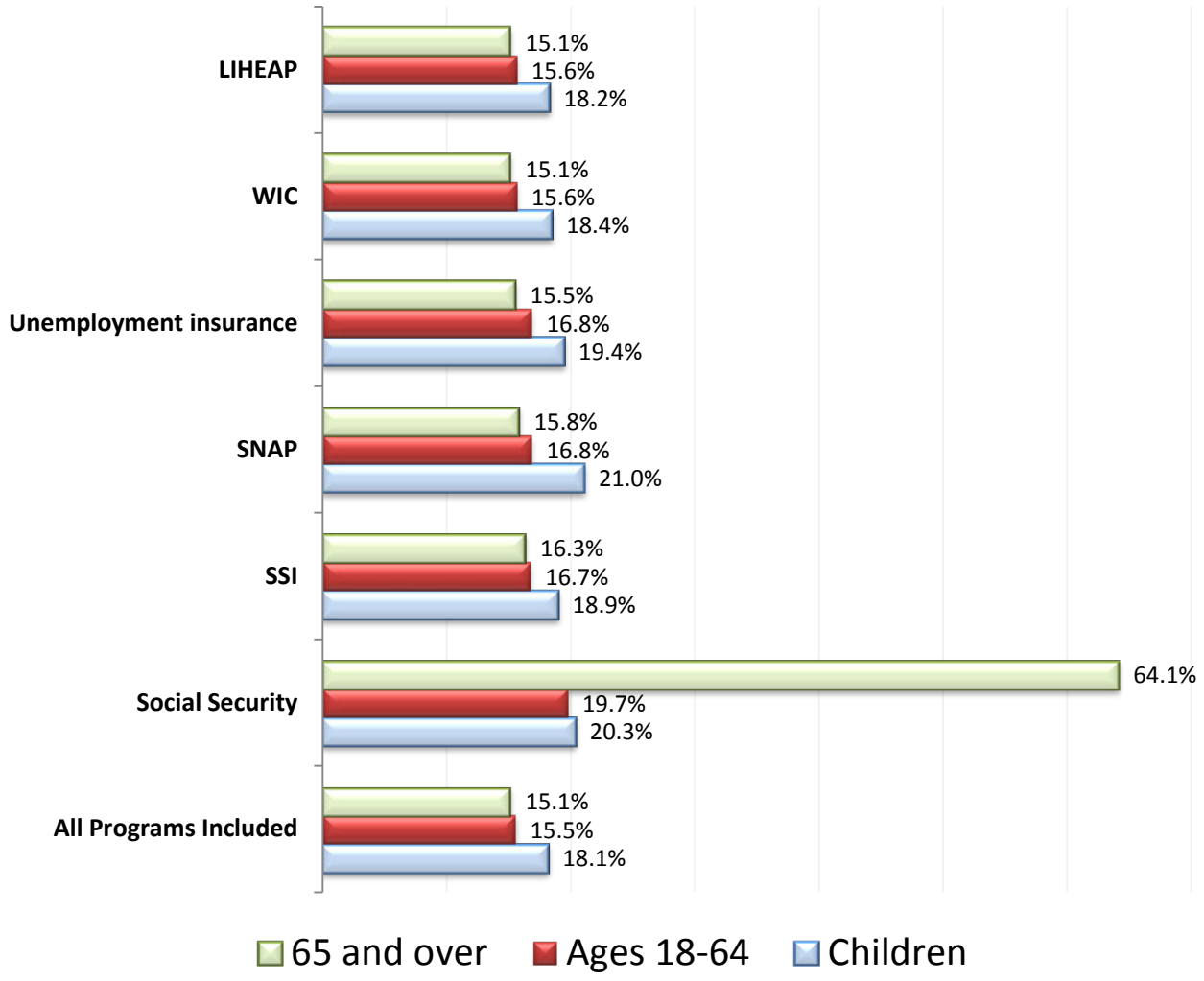


Source: U. S. Census Bureau, Current Population Survey, 2011 and 2012 Annual Social and Economic Supplements

When the official measure was created in 1964, many of the federal assistance programs did not exist. Although it has been adjusted for inflation, the formula remains the same and is based on a family of 4 spending 30% of their income on food. Chart 30 compares the supplemental poverty rate with and without specific programs. As in the previous chart, it also shows the projected supplemental poverty rate would significantly increase for those aged 65 and over without Social Security benefits. The rate of poverty for minor children would increase from 18.1% to 21% without SNAP benefits.

It is important for the differences between the official and supplemental poverty measures to be examined to more reasonably reflect contemporary social and economic circumstances, particularly concerning government policies. If programs are designed to help people who are in need, it is important to have a better understanding of whose lives are affected most by insufficient income.

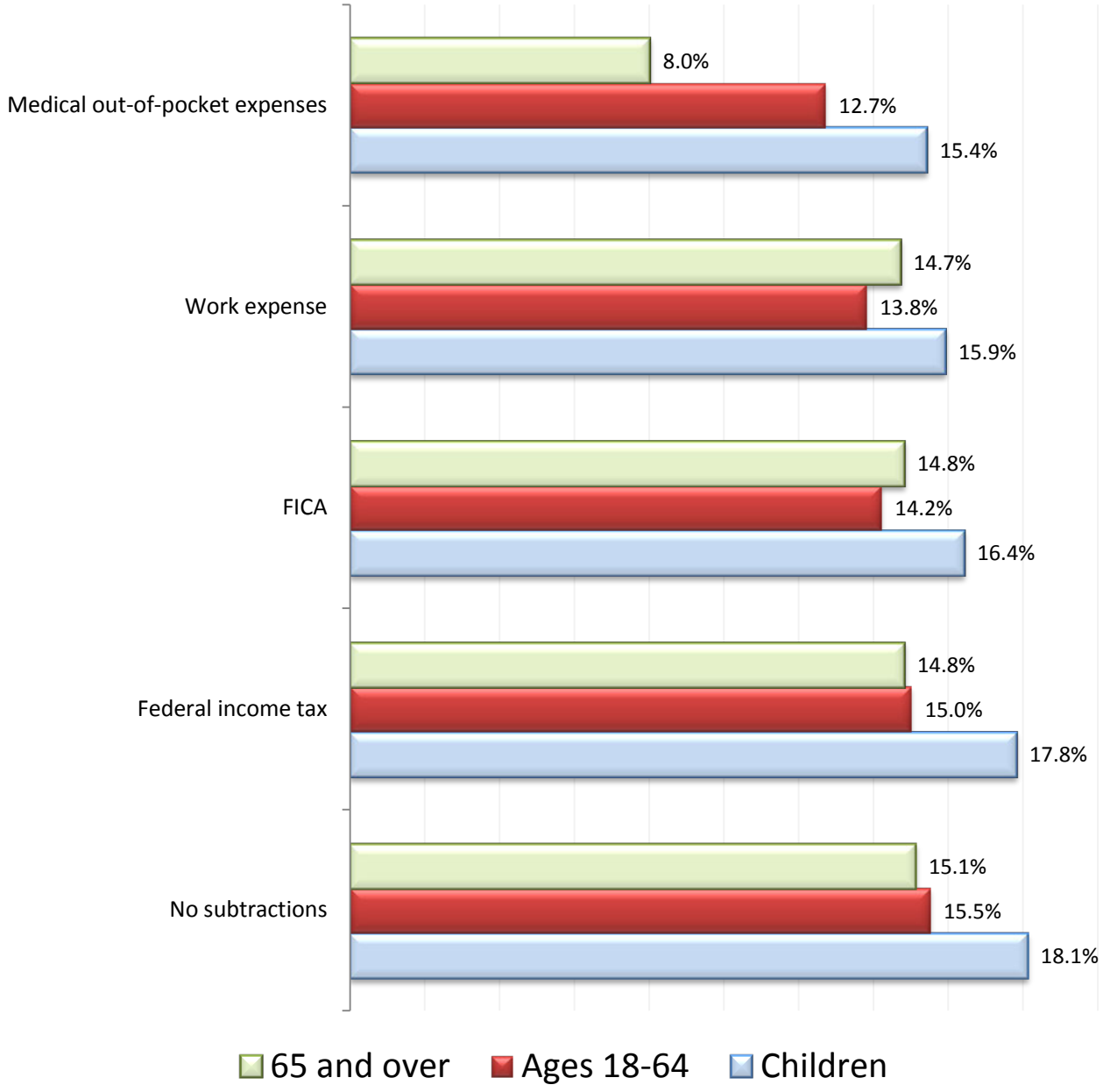
Chart 30: Projected Supplemental Poverty Rate Without Specific Programs, By Age Category
U. S., 2011



Source: 2011 Research Supplemental Poverty Measure-Current Population Report, November 2012

Chart 31 shows how the deduction of expenses would affect the supplemental poverty rate for different age categories. It shows that subtractions of these expenses would primarily affect seniors (who have more medical out-of-pocket expenses and working age persons (who have transportation costs and pay FICA and federal income tax).

Chart 31: Projected Poverty Rate With Subtractions of Specific Expenses, By Age Category
U. S., 2011



Source: 2011 Research Supplemental Poverty Measure-Current Population Report, November 2012

Measuring Human Development

The Measure of America 2010-2011 is described in the 2011 Community Needs Evaluation (pages 41-45). However, there are new findings that are relevant to the factors on which rankings are determined (health, education and income).

The Opportunity Index provides a snapshot of counties and states to show the conditions in communities, including whether the community, private sector, foundation and government actions and investments are expanding opportunity for all. The *2012 Opportunity Index – Measuring Opportunity in Your Community* describes Opportunity indicators:

- Jobs and the Local Economy Indicators are employment, wages, poverty, inequality, assets, affordable housing and internet access. This would include jobs that will support long-term opportunity, housing in an area with good schools, a vehicle and savings to weather unpredictable economic downturns.

- Education Indicators are preschool enrollment, on-time high school graduation and percentage of adults with an associate's degree or above. This would include an increase in educational attainment to increase lifetime incomes and to improve "dropout factory" high schools.

- Community Health and Civic Life Indicators are membership in community groups, volunteerism, the percentage of young people ages 16 to 24 who are neither working nor in school, community safety, access to health care, and access to healthy food. This would include an expansion of social capital, such as volunteerism and group membership that are correlated to community trust.

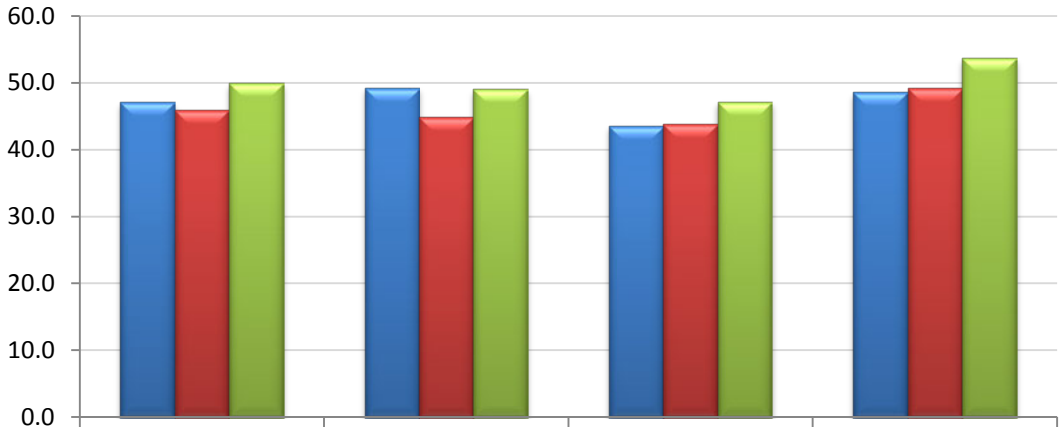
The report on the Opportunity Index explains that where a person lives is a critical factor in the opportunities available to them. Some places have characteristics that enhance options for opportunities for residents, while others do not. Factors that influence opportunity include the level of accessibility to employment, education, housing quality, transportation, green space, access to health care, law enforcement/public safety, community organizations and political processes. The Opportunity Index expands the approach from economic indicators to include also related academic, civic and other factors.

Based on a possible Opportunity Score of 100, Tennessee scored 45.9, far below the highest scores of more than 60 for Vermont, North Dakota, Minnesota and New Hampshire. While the top three states are not the wealthiest for income, they excel at other important characteristics. Tennessee ranked 39th out of 51 (50 states and the District of Columbia). Some southeastern states ranked even lower than Tennessee – Florida, South Carolina, Georgia, Arkansas, Louisiana, Alabama and Mississippi.

As shown in Chart 23, Davidson County's rankings were lower than the national average for Opportunity, Education and Community, while it was slightly higher for the Economy. Tennessee's average was lower than Davidson County's scores for Opportunity and the Economy but higher for Education and Community.

Chart 32: Opportunity Ranking by Category

Davidson County, Tennessee, U. S.



	Opportunity	Economy	Education	Community
Davidson County	47.1	49.3	43.6	48.6
Tennessee	46.0	44.9	43.8	49.2
U. S.	50.0	49.1	47.2	53.7

Source: Opportunity Scores, *Measuring America*

The *Opportunity* report suggests that nonprofit organizations, the business community, philanthropists and government should focus on specific characteristics associated with low Opportunity scores:

- States with higher youth disconnection (on-time graduation, post-secondary education)
- Voter turnout
- Poverty rate (high poverty rates for counties and lower educational attainment at the state level are related to low opportunity)
- Inequality is associated with higher crime rates and lower levels of civic engagement

http://www.measureofamerica.org/opportunityindex/

The Widening Academic Achievement Gap Between the Rich and the Poor: New Evidence and Possible Explanations (July 2011) from the Stanford University's Center for Education Policy Analysis noted that the socioeconomic status of a child's parents continues to be one of the strongest predictors of the child's academic achievement and educational attainment. It found that as the income gap between high-income and low-income families increased during the past four decades, the achievement gap for children from these families has also widened. The achievement gap between children from high- and low-income families is about 30-40% higher for children born in 2001 than for those born 25 years earlier. Part of the gap may be attributed to increasing parental investment in children's cognitive development. Family income is now nearly as strong as parental education in predicting children's achievement.

http://cepa.stanford.edu/sites/default/files/reardon%20whither%20opportunity%20-%20chapter%205.pdf

Food and Nutrition

Key Findings

- **Tennessee ranks 8th among all states in Food Hardship.**
- **Food costs have increased by 13.3% over the past five years.**
- **One in six Americans, including 16.2 million children, struggle with hunger.**
- **Emergency Food requests are up at Second Harvest Food Bank and the 2-1-1 Call Center.**
- **Supplemental Nutrition Assistance Program (formerly food stamps) participation is up locally, statewide and nationally.**
- **Unemployment and stagnant wages are the primary causes of food insecurity for families.**

Food Security

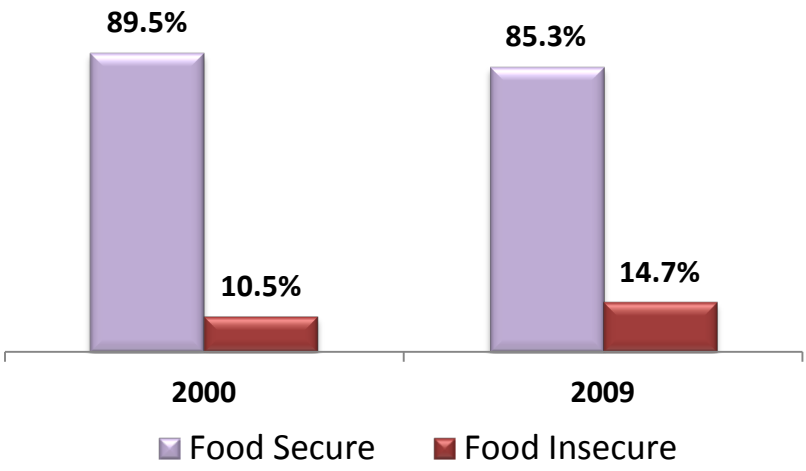
The U.S. Census 2012 Statistical Abstract defines food security as access by all members at all times to enough food for an active healthy life. To be food secure, household members need nutritious and safe food readily available at all times and the ability to acquire such food in socially acceptable ways without resorting to emergency food sources. Food insecurity has been linked to mental and physical health challenges for persons who do not receive enough nutritious foods. In addition, food insecurity can have negative consequences for pregnant women and overall child well-being.

http://feedingamerica.org/hunger-in-america/impact-of-hunger/physical-and-mental-health.aspx

Food insecurity for all households increased from 10.5% to 14.7% between 2000 and 2009, as shown in Chart F-1. Households that are food insecure are concerned about having enough money to pay for food during the month and in some cases are not sure where their next meal will come from.

Source: Census 2012 Statistical Abstract

Chart F-1: Food Security Status for All Households
U. S., 2000, 2009

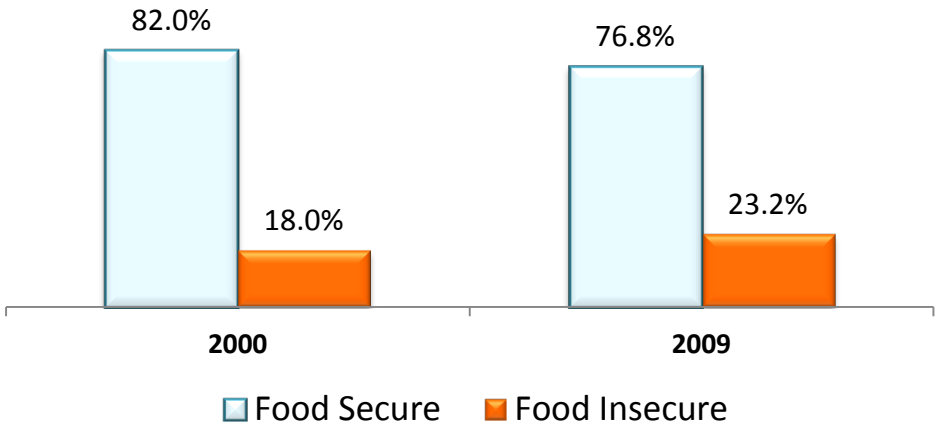


According to the U.S. Census Bureau's Current Population Survey, December 2010 Food Security Supplement:

- 14.9% of U.S. Households were food insecure.
- 9.8% of U.S. Households with children were food insecure.
- 59% of food insecure households reported using a Federal Food Assistance Nutrition Program such as food stamps, WIC, free or reduced price school lunch or summer food program.

Chart F-2 shows that the percentage of households with children where there was food insecurity increased from 18% in 2000 to 23.2% in 2009. This means that nearly one out of every four children in the U. S. did not receive adequate amounts of food during the month and were also concerned about where there next meal would come from.

Chart F-2: Food Security Status for Households With Children
U.S., 2000, 2009



Source: Census 2012 Statistical Abstract

According to the United States Department of Agriculture's *Household Food Security in the United States 2011* report, enrollment in the three major federal nutrition programs (Women Infant and Children, Free or Reduced Price School Lunch and Supplemental Nutrition Assistance Program) continues to increase.

Hunger in Davidson County

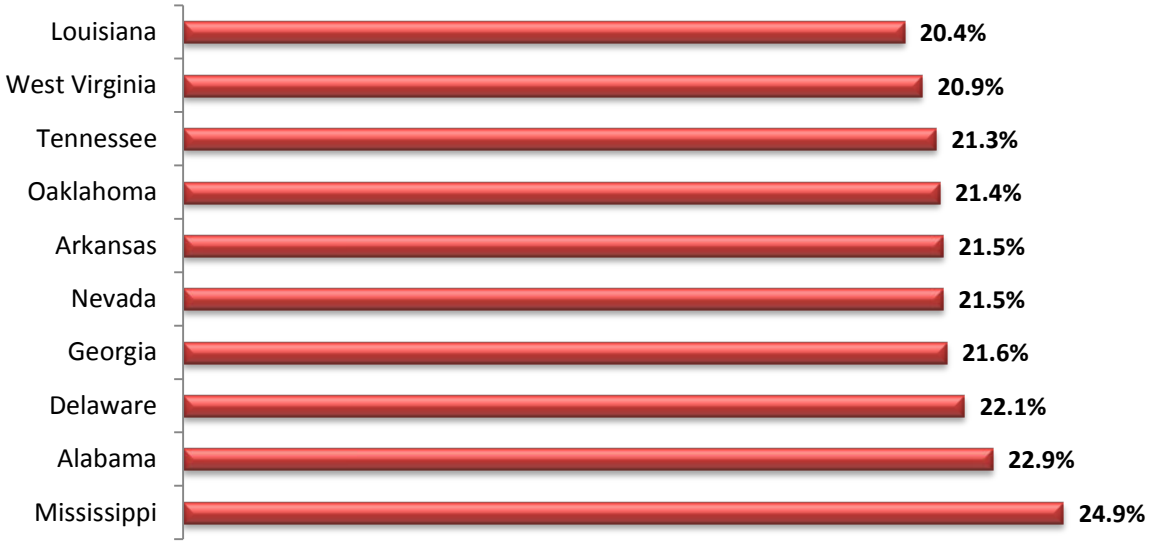
The U.S. Conference of Mayors *2012 Status Report on Hunger and Homelessness* indicates that in Nashville, the requests for emergency food assistance increased 8% from the previous year. However, 30% of the requests for emergency food assistance went unmet. The report identified the primary causes for hunger in individuals and households with children are unemployment, high housing costs and substance abuse.
http://www.usmayors.org/pressreleases/uploads/2012/1219-report-HH.pdf

Food Hardship in Tennessee

A Gallup poll conducted in January through June 2012 reported that Tennessee ranked 8th among the top states in which residents struggled to afford needed food items. As indicated in Chart F-3, in Tennessee, one-in-five persons are without enough money to afford food.

Chart F-3: Percent of Residents Without Enough Money for Food

Among Top 10 Food Hardship States, January - June 2012



Source: http://www.gallup.com/poll/156806/one-four-mississippi-residents-struggle-afford-food.aspx

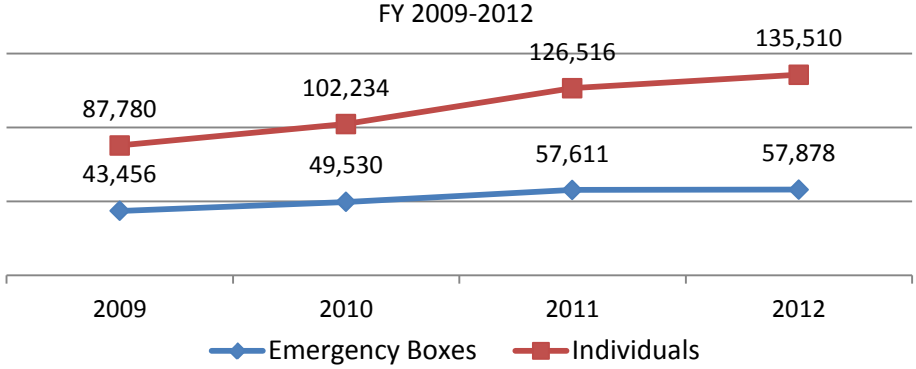
Second Harvest Food Bank of Middle Tennessee

Second Harvest Food Bank of Middle Tennessee is the largest emergency food distributor in the 46 county Middle Tennessee areas. Second Harvest uses a network of growers, manufacturers, wholesalers and grocery stores and individuals to donate food to their food pantries or partner organizations. Chart F-4 shows a steady increase over the past four years in the number of emergency food boxes distributed and individuals served.

Chart F-4: Emergency Food Distribution,

Second Harvest Food Bank

FY 2009-2012



Source: Second Harvest Food Bank of Middle Tennessee

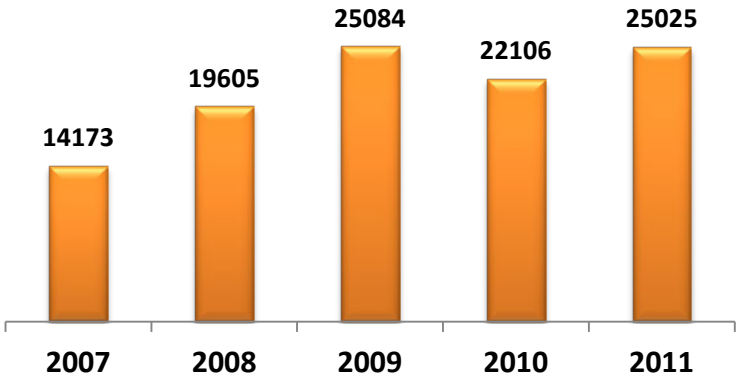
Second Harvest Food Bank of Middle Tennessee reported that in FY 2012 387,352 food insecure individuals were served in their forty-six county service area. Second Harvest provided over sixteen million meals and distributed over 19 million pounds of food during the year, up by 18% over 2011. When Second Harvest conducted a survey of participants who received emergency food, many indicated they had to make a choice between purchasing food and paying utilities or rent.

2-1-1 Call Center

As described earlier in this document, the 2-1-1 Call Center provides information about social and human service needs. From 2007 through September 2012, housing and utility assistance consistently ranked highest in the number of requests to the 2-1-1 call center. Requests for Food/Meals ranked second highest in number of requests. Food request are referred to food pantries, food Stamps, Meals on Wheels and the Women Infant and Children (WIC) Program.

Chart F-5: 2-1-1 Calls for Food/Meals

2007-2011



As shown in Chart F-5, 2-1-1 calls for food/meals are up from 2010 to 2011 but slightly below 2009 requests. The 2009 peak was likely because it was during the recession.

Source: United Way of Metropolitan Nashville

Supplemental Nutrition Assistance Program (SNAP)

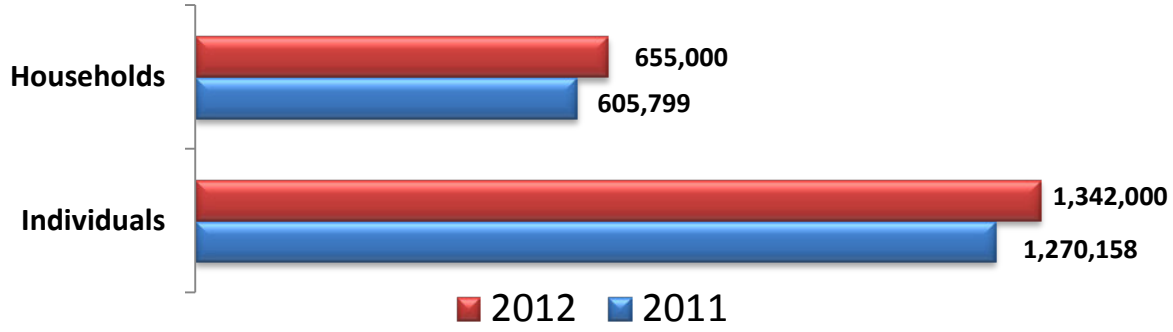
Tennessee and Davidson County SNAP participation rate has been above the national average for the past five years, as indicated by the data below. According to the data from the American Community Surveys from 2007-2011, Tennessee's 2011 SNAP participation rate was 35% higher than the national average. For the same 2011 period, Davidson County's SNAP participation rate was 21% higher than the national average.

Percentage With SNAP Benefits in Past Five Years	2007	2008	2009	2010	2011
United States	7.7%	8.6%	10.3%	11.9%	13.0%
Tennessee	12.1%	12.8%	15.3%	17.0%	17.6%
Davidson County	8.7%	11.3%	12.9%	16.5%	15.8%

As shown in Chart F-6, the number of households and the number of individuals receiving SNAP benefits increased from 2011 to 2012. The number of households in Tennessee receiving SNAP benefits increased by 8.1% and the number of households increased by 5.6% between fiscal years 2011 and 2012.

Chart F-6: Number of SNAP Recipients

Tennessee, FY 2011-2012



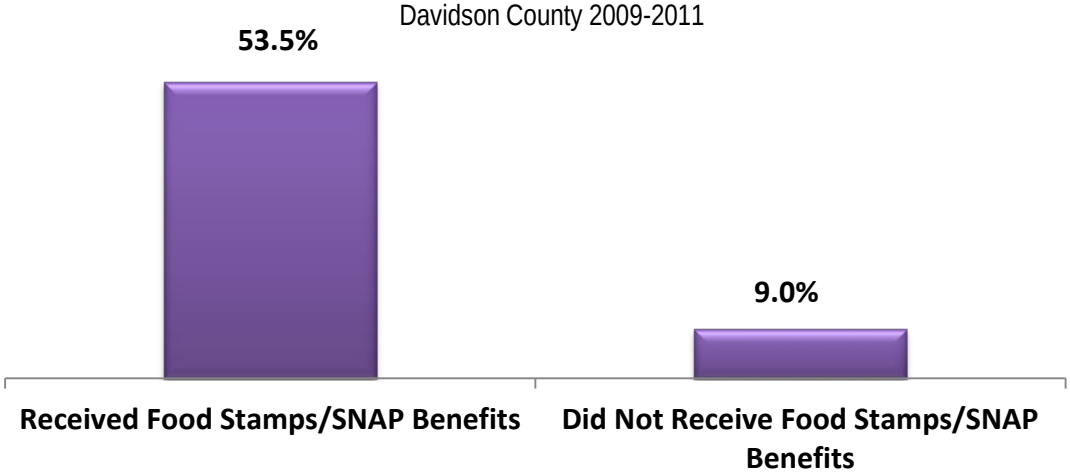
Source: Tennessee Department of Human Services 2010-2011 and 2011-2012 Annual Report
http://www.tn.gov/humanserv/pubs/DHS-AR.pdf
http://www.tn.gov/humanserv/pubs/DHS-AR11-12.pdf

SNAP Benefits and Poverty

Households in poverty are far more likely to use SNAP benefits than others. As shown in Chart F-7, 53.5% of households below the poverty level received SNAP benefits, while 9% of households below the poverty level did not receive SNAP benefits. Several factors could be attributed to why persons below the poverty level chose not to receive benefits, including stigma associated with food stamp assistance, not knowing where/how to apply or not interested.

Chart F-7: Percent of Households Below Poverty Level by SNAP Benefit Status

Davidson County 2009-2011



Source: American Community Survey 2009-2011 Table B22003

The U. S. Department of Agriculture conducted research about why families left the SNAP program. *Food Insecurity After Leaving SNAP* reported that about 1/3 of those who left the SNAP program returned the next year. For that group, their incidence of very low food security was even lower (20.2%) than those who remained in the program (11.8%). The group who left and returned continued to have higher rates of very low food security (19.5%) than those who remained in the program.

Compared to a group that left the SNAP program and did not return to the program the next year, they had more low food security (13.9%) shortly after leaving SNAP. However, the rate of low food insecurity decreased to 10.0%, which was lower than those who had remained on the program at 11.7%. Researchers found that most who left and remained out of the SNAP program left because they had better employment and higher incomes. The elevated rate of low food security for both groups shortly after leaving the SNAP program suggests that a period of transition may be needed to improve food security for those who leave the SNAP program, regardless of whether they return to the program or not.
http://www.ers.usda.gov/media/227605/snapfoodneeds_1_.pdf

SNAP Utilization Projections
The Congressional Budget Office predicts that SNAP participation will decline over the next ten years, as the economy improves and more people become employed. The report indicates that the decline may begin as early as 2014. SNAP participation and spending reached an all-time high in 2011 with one-in-seven people participating and federal spending at $78 billion dollars. The report also highlights policy changes that could affect eligibility for future SNAP beneficiaries, such as changing the eligibility requirements so that fewer people would be eligible for benefits by adjusting the income/asset requirements.
http://www.cbo.gov/sites/default/files/cbofiles/attachments/04-19-SNAP.pdf

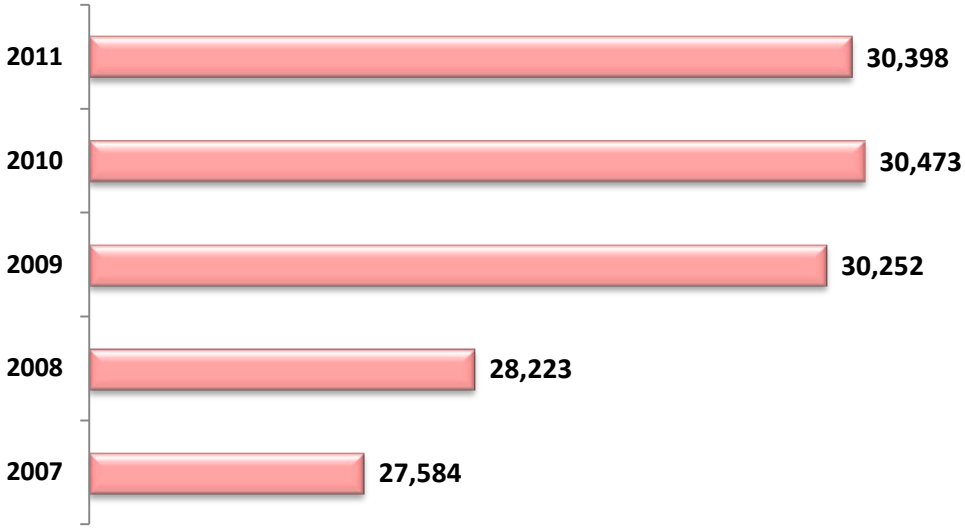
Special Populations

Women, Infants and Children Supplemental Food Program (WIC)
WIC is a supplemental nutrition program that provides nutrition education, promotes breastfeeding, and provides food vouchers that program participants can use in area stores. The Metropolitan Public Health Department makes the WIC program available to pregnant, post-partum women, infants and children up to age five who meet income guidelines.

As shown in Chart F-8, the WIC program participation rate did not change significantly in 2010-2011, after rising the previous three years. In an effort to increase participation, WIC opened a new clinic in

the Southeast portion of Davidson County and partnered with agencies such as United Neighborhood Health Services to expand nutrition education classes for eligible participants.

Chart F-8: Number of WIC Participants
Davidson County, 2007-2011



Source: Metropolitan Health Department Women, Infants and Children Supplemental Food Program

Free or Reduced Cost Lunches for Public School Students

Free or Reduced Cost lunches continue to provide nearly three-fourths of public school students with nutritious meals. With 74,680 students enrolled in the 2011-2012 school year, the public school students rely on the federally funded school lunch program to meet their nutritional needs.

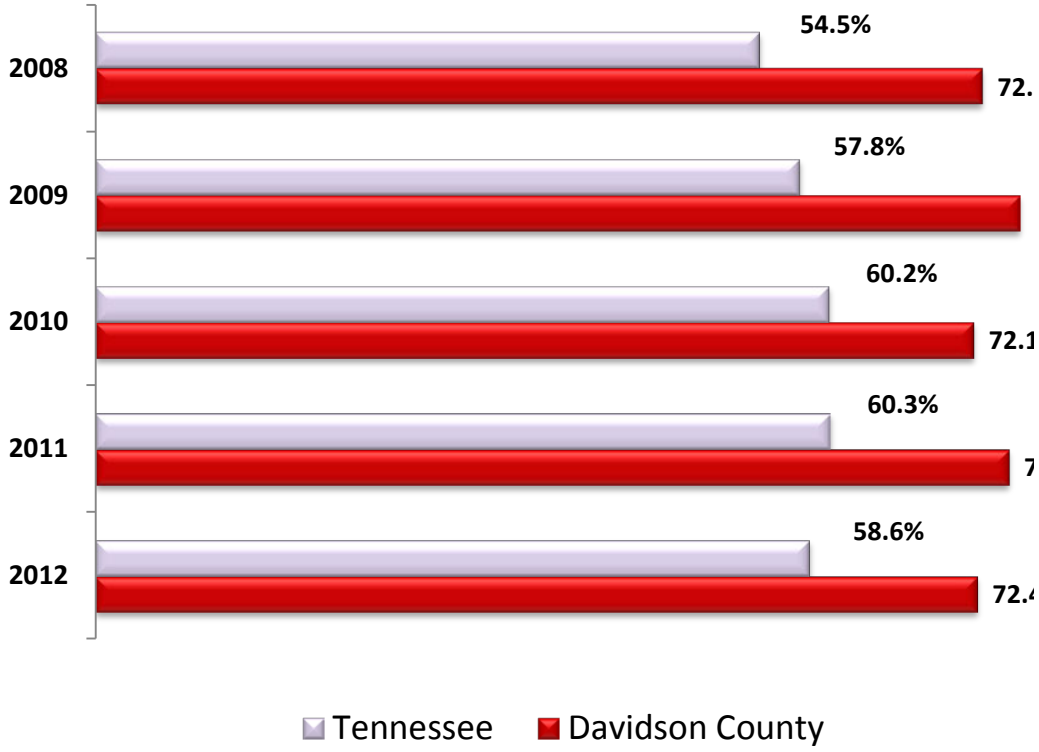
Recent efforts through community organizations, such as Alignment Nashville's School Food Committee, focused on including fresh fruits, vegetables and whole grain products as part of school lunch offerings.

Programs like Helping Us Grow in elementary schools are teaching young student how to grow their own foods as part an approved curriculum. School gardens are now in a few middle schools, and the produce grown is used in the school cafeterias.

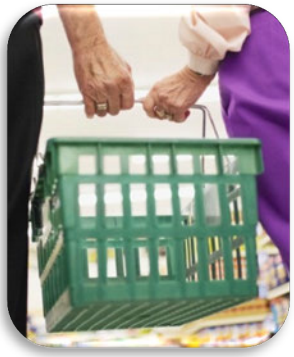
Chart F-9 shows that Davidson County's Free or Reduced Cost lunch utilization rates have remained higher than the statewide rates during the past five years.

Chart F-9: Percentage of Public Shool Students Receiving Free or Reduced Cost Lunch

Davidson County and Tennessee, 2008-2012



Source: Tennessee Department of Education Report Card



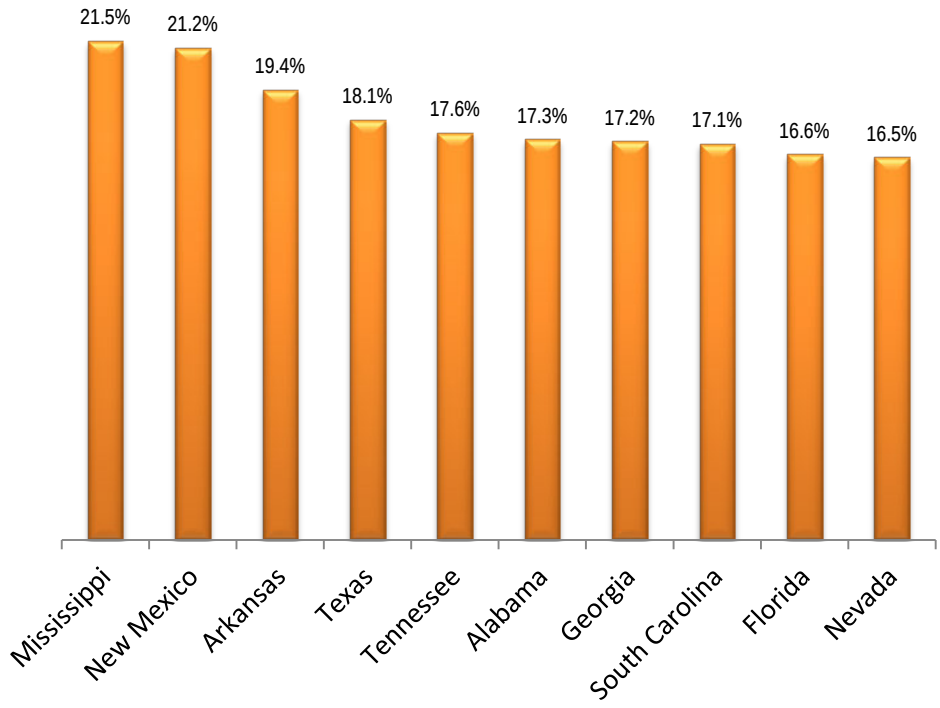
Senior Hunger

According to the *Senior Hunger in America 2010 Annual Report from the Meals on Wheels Research Foundation*, one-in-seven seniors faced the threat of hunger, up from one-in-nine in 2005. Race, ethnicity and income were contributing factors for seniors facing the threat of hunger.

Seniors who were more likely to face the threat of hunger tended to live in the south or southwest, were between ages 60-69 and were racial or ethnic minorities and had lower incomes.

Chart F-10 shows the states with the highest percentage of seniors facing hunger in 2010, most in the southeast part of the U.S.

Chart F-10: Percentage of Senior Facing Threat of Hunger
U. S., 2010



Source: Meals on Wheels Foundation Annual Report http://www.mowrf.org/The2010AnnualReport.pdf

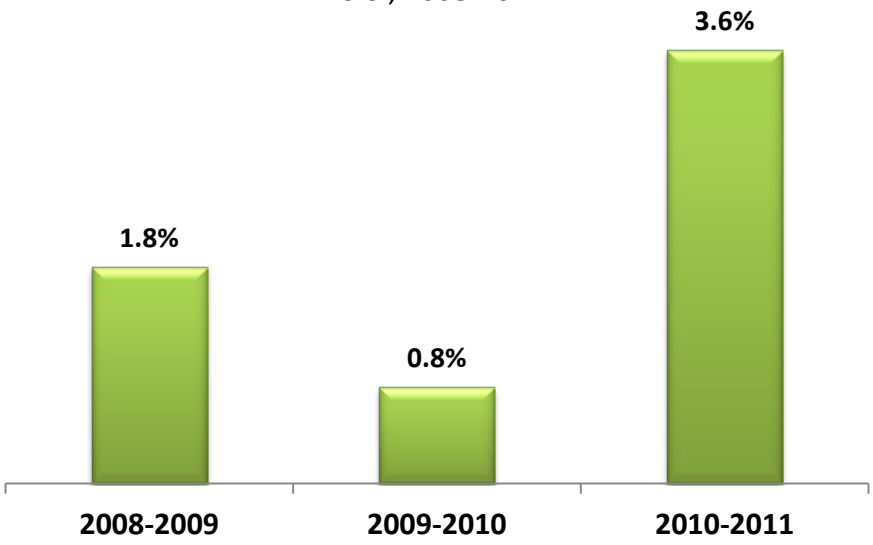
In the Mid-Cumberland Region (other than in Davidson County), Second Harvest Food Bank of Middle Tennessee is piloting a Senior Backpack program that partners with Senior Housing facilities and Meals on Wheels programs to distribute food to seniors who have limited mobility. Another program that assists seniors with food is the Commodities Supplemental Food Program of the Metropolitan Public Health Department, which increased the number of food boxes distributed to seniors and worked to make fresh fruits and vegetables available at their distributions sites by working with local farmers.

Increasing Cost of Food

The U. S. Bureau of Labor Statistics Consumer Price Index Report reported that in 2011, food prices increased by 3.7% from 2010 Because of the continuing escalation in the cost of food, it is difficult for low-income families to purchase both food and other basic need items such as housing, utilities, transportation, childcare and clothing. Despite the increased cost of food, federal food assistance programs such as SNAP and WIC have not increased funding to meet the increased cost of food.

Chart F-11 shows that food costs have increased nationwide during the past 3 years.

Chart F-11: Food Cost Increases in Consumer Price Index
U.S., 2008-2011



Source: Consumer Price Index for All Urban Consumers 2008-2011
http://www.bls.gov/news.release/cpi.t07.htm
http://www.bls.gov/cpi/cpid11av.pdf

Nutrition and Health

Proper nutrition is an important component of good health. Fresh, healthy foods are important in achieving a healthy weight and lifestyle.

Access to Nutritious and Healthy Foods

Access to affordable and healthy foods for low-income communities continues to be a challenge nationally and locally, and several strategies are being used to address these issues. These include improving school food by encouraging students to eat more fruits and vegetables, increasing the number of school gardening programs, encouraging community gardening groups to expand the types of vegetables grown and increasing nutrition education in schools and community groups. The U.S. Conference of Mayors has highlighted the need to make nutritious food available to low-income families, coupled with improvements in community wide nutrition education programs. In Nashville, the NashVitality initiative was implemented to promote healthy eating, exercise and proper nutrition.

The U.S. Centers for Disease Control has a number of reports that describe the importance of healthy foods, especially in low-income neighborhoods. It explains that the food environment may be known as the community food environment, nutritional food environment or local food environment. In addition, it describes the connection between food and health status and provides information about how access can be improved to healthy foods.
http://www.cdc.gov/healthyplaces/healthtopics/healthyfood/general.htm

Obesity

The Center for Disease Control (CDC) indicates that one-third of all adults in the U.S. are obese. Obesity has contributed to several chronic diseases such as diabetes, strokes, heart disease and cancer. Obesity has also been linked to the rising cost of medical care in the U.S. In Tennessee, the prevalence of reported obesity was 29.2% of the adult population in 2011. In 2010, Tennessee's obesity rate was 30.8% indicating a slight decrease over the past year. Mississippi had the highest prevalence of reported obesity in the nation at 34.9% of its adult population in 2010 with Colorado the lowest at 21%.

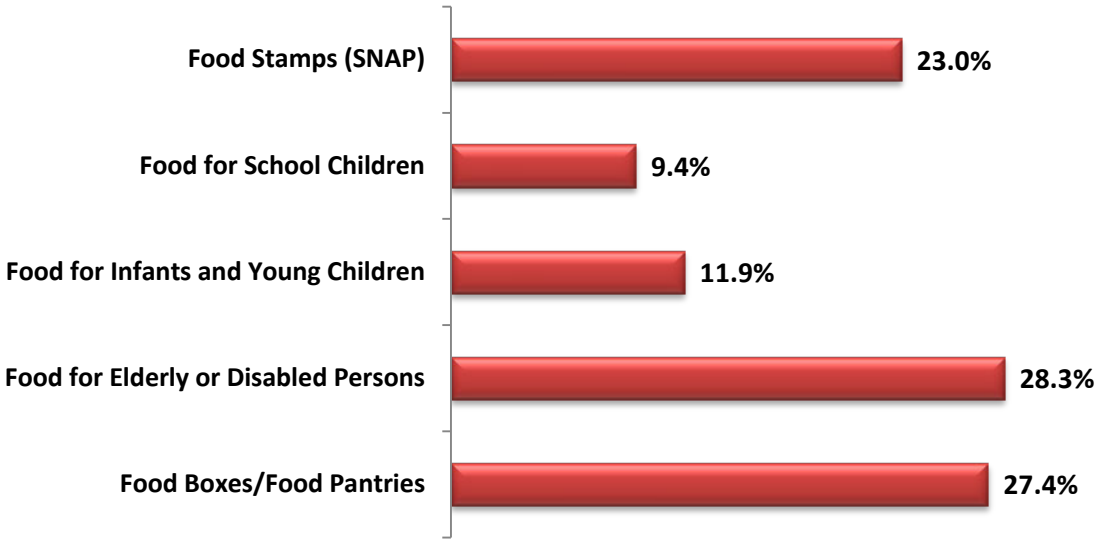
http://www.cdc.gov/obesity/data/adult.html

Grassroots Community Survey

When asked to identify the greatest need in Food and Nutrition, 28.3% of the respondents to the 2012 Grassroots Community Survey identified food for elderly or disabled persons as the most frequent need. As shown in Chart F-12, food for the elderly and disabled was followed closely by the need for food pantries/food boxes at 27.4% and Food Stamps 23% as the greatest need identified by respondents. In 2011, the greatest need in food and nutrition was food stamps by more than half of the respondents 51.4%.

Chart F-12 : Greatest Need in Food

2012 Grassroots Community Survey

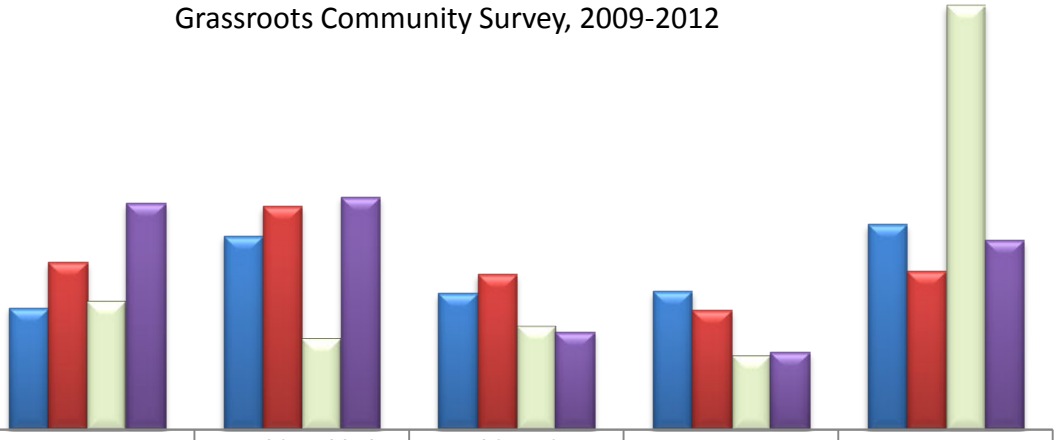


Source: 2012 Grassroots Community Survey

Chart F-13 compares the specific needs identified by respondents during the 4 years the survey has been conducted.

Chart F-13: Greatest Need in Food

Grassroots Community Survey, 2009-2012



	Food Boxes/Food Pantries	Food for Elderly or Disabled Persons	Food for Infants and Young Children	Food for School Children	Food Stamps
2009	14.8%	23.5%	16.5%	16.8%	24.9%
2010	20.3%	27.1%	18.9%	14.5%	19.2%
2011	15.64%	11.17%	12.66%	9.12%	51.40%
2012	27.4%	28.3%	11.9%	9.4%	23.0%

Source: 2009-2012 Grassroots Community Survey

Health and Human Development

Key Findings

- **Living in low socioeconomic circumstances increases the risks for mortality, morbidity, unhealthy behaviors, and reduced access to health care along with inadequate quality of care.**
- **Research shows that about one-third of the 577,190 cancer deaths expected to occur in 2012 may be related to obesity, physical inactivity, and poor nutrition all of which could be prevented.**
- **Poor prenatal care increases the likelihood of obesity in childhood and adulthood, as well as hypertension and heart disease.**
- **Homeless children are sick four times more often than other children, with four times as many respiratory infections, twice as many ear infections, and five times more gastrointestinal problems.**
- **The lack of dental care affects overall health and increases the risk for diabetes, heart disease, and poor birth outcomes.**
- **About 13 million American adults (1 in 17) live with serious mental illnesses.**
- **High-quality development experiences in the early years of life increase the opportunities for academic success from grades K-12 and beyond.**

Health

Health

America's Health Rankings 2012 from the United Healthcare Foundation ranked the state of Tennessee's overall health as the 39th state out of the 50 states, an improvement from the previous year's state ranking of 42nd. *America's Health Rankings 2012* also reported that there are multiple factors that contribute to the health status of all states that include individual behaviors, culture, the environment, economic factors, social determinants, and genetics. The report also indicates that the poor health outcomes of Tennesseans were likely related to the state's lack of an integrated system of health care. The following table identifies the 10 leading causes of death of Tennesseans, according to the Tennessee Department of Health.

Top 10 Leading Causes of Death for Tennessee Residents per 100,000 people	Number	Rate
Total Resident Deaths	59,201	932.9
Heart Diseases	14,489	228.3
Cancer	13,514	212.9
Chronic Lower Respiratory Diseases	3,525	55.5
Accidents and Adverse Effects	3,472	54.7
Stroke and Cerebrovascular Disease	3,178	50.1
Alzheimer's Disease	2,428	38.3
Diabetes	1,678	26.4
Pneumonia and Influenza	1,347	21.2
Kidney Disease	974	15.3
Suicide	932	14.7

Source: 2011 State Health Plan, the Tennessee Department of Health, Office of Policy Planning and Assessment, Division of Health Statistics

Health Disparities

The U. S. National Institutes of Health describes health disparities as the "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States." Such disparities are often related to poverty or other specific characteristics.

The *CDC's Health Disparities and Inequalities Report- United States 2011* explained that one of the primary goals of the CDC is to eliminate disparities of health between segments of the U. S. population. The report notes that health disparities are variations in health outcomes and their determinants between population groups that are defined by social, demographic, environmental and geographic characteristics. The term health inequalities are more often used in research literature to refer to differences that are associated with specific aspects, such as income, education, and race/ethnicity. The report includes a detailed analysis of health determinants for various types of diseases.
http://www.cdc.gov/mmwr/pdf/other/su6001.pdf

The first edition of Tennessee's *State Health* Plan was developed in 2009 to begin a "participatory health planning process to coordinate Tennessee's efforts to improve health." The 2011 State Health Plan was developed by the State of Tennessee's Division of Health Care Finance and Administration to address Tennessee's health care needs. The report explained that many factors affect health, including what a person does, where they live, the people that live around them, their income, educational attainment and the genes received from their parents. It noted illustrations of how Tennesseans compare less than favorably to some national statistics:

- Tennesseans are expected to live an average of 3 years less than the average U.S. citizen (75 years as compared to 78 years).
- In Tennessee, for every 1,000 infants born, 9 die in Tennessee compared to 7 that die nationwide.

http://www.tn.gov/finance/healthplanning/Documents/StateHealthPlan2011FINAL12-21-11.pdf

The CDC noted that there has been substantial progress in reducing disparities in the U.S., but that disparities still exist by race and ethnicity, income and education, disability status and other characteristics. The CDC has identified the need for a dual strategy, using both nationally and locally identified intervention strategies for populations with specific needs.
http://www.cdc.gov/minorityhealth/CHDIReport.html

In terms of disparities for people with disabilities, the CDC reported that there is a health care disparity in terms of health care access. In 2010, 29% of people with disabilities reported unmet health care needs, compared with 12% of those without disabilities. It explains that health care access means far more than insurance coverage. Access includes physical access to buildings and appointments (structurally accessible and available transportation), accessible health information, attitudes of health care providers, etc.

Health is affected not only by the disability but also by additional factors, many that could be prevented. These include depression, pressure ulcers, chronic conditions, and overall maintenance of good health care.
http://www.cdc.gov/ncbddd/AboutUs/human-development-disability.html

Causes of disease and death for Tennessee men and women are described below. In addition, there are disparities in modifiable risk factors. For many (but not all) factors, minority groups have more negative health outcomes, including some modifiable risk behaviors. Examples from the *Health Report Cards* include:

- Men with new HIV/AIDS cases (per 100,000) – 85.4 African American, 8.2 White, 31.6 Hispanic
- Men with Gonorrhea (per 100,000) – 523.3 African American, 14.7, White, 34.5 Hispanic
- Women with Gonorrhea (per 100,000) – 644.9 African American, 41.9 White, 166.5 Hispanic
- Women with high blood pressure – 46.3% African American, 31.1% White
- Women with high cholesterol – 28.8% African American, 32.8% White
- Women who are obese – 52.7%% African American, 30.7% White
- Women smokers – 15.0% African American, 20.8% White

Causes of Disease and Death for Tennessee Men

According to the 2012 *Tennessee Men's Health Report Card*, heart disease among men age 65 and older is often attributed to obesity, lack of exercise, smoking, high blood pressure, high cholesterol, diabetes, and poor nutrition. It indicated that while death rates have decreased, heart disease remains the leading cause of death for men in Tennessee age 65 and older. It also stated that the percentage of men in Tennessee who smoke cigarettes has declined, but there is an ongoing need for improvement because about 6,000 Tennessee men still die each year from smoking.

Using 2010 data, *the 2012 Tennessee Men's Health Report Card* included grades to reflect Tennessee's performance in comparison to the national health objectives from the Healthy People 2020 framework. The grade guidelines were:

A = Better than, equal to, or no more than 10% worse than the HP2020 goal

B = 10-30% worse than the HP2020 goal

C = 30-60% worse than the HP2020 goal

D = 60-100% worse than the HP2020 goal

F = More than 100% worse than the HP2020 goal

http://medicineandpublichealth.vanderbilt.edu/TNmenshealthreportcard_2012.pdf http://healthypeople.gov/2020/about/aboutdata.aspx

Areas identified below are those in which Tennessee men fared worse than the national goal for causes of death.

Cause of Death	2010	Grade
Cancer *(All cancers combined)*	All: 317.6	D
Per 100,000 Men	White: 342.5	F
	African American: 284.0	D
Stroke	All: 54.5	D
Per 100,000 Men	White: 56.7	D
	African American: 58.8	D
Chronic Liver Disease and Cirrhosis	All: 20.7	F
Per 100,000 Men	White: 23.2	F
	African American: 13.6	D
Motor Vehicle Accident	All: 29.4	F
Per 100,000 Men	White: 31.7	F
	African American: 22.9	D
Acquired Immune Deficiency Syndrome	All: 6.3	D
(AIDS) Per 100,000 Men	White: 3.2	A
	African American: 25.2	F
Homicide	All: 12.2	F
Per 100,000 Men	White: 7.2	C
	African American: 42.3	F
Unintentional Injury	All: 57.9	D
Per 100,000 Men	White: 62.3	D
	African American: 51.3	C
Suicide	All: 30.4	F
Per 100,000 Men	White: 34.9	F
	African American: 13.3	C

http://medicineandpublichealth.vanderbilt.edu/TNmenshealthreportcard_2012.pdf

Causes of Disease and Death for Tennessee Women

Based on 2009 data, the 2011 *Tennessee's Women Health Report Card* described the leading causes of deaths for women. Those identified with poor grades in Tennessee are listed below, using the following guidelines for grades:

A = Equal or better than HP 2020 goal or less than 25% improved from 2004 to 2009

B = 1 - 30% worse than HP 2020 goal or 10 - 25% improved from 2004 to 2009

C = 30 - 60% worse than HP 2020 goal or between 10% improved and 10% worse from 2004 to 2009

D = 60 - 90% worse than HP 2020 goal or 10 - 25% worse from 2004 to 2009

F = 90% worse than HP 2020 goal or more than 25% worse from 2004 to 2009

Cause of Death	2009	Grade
Cancer *(All cancers combined)*	All: 317.6	D
Per 100,000 Women	White: 342.5	F
	African American: 284.0	D
Stroke	All: 70.4	F
Per 100,000 Women	White: 72.4	F
	African American: 65.4	F
Breast Cancer	All: 34.1	D
Per 100,000 Women	White: 33.4	D
	African American: 41.1	F
Cervical Cancer	All: 3.6	D
Per 100,000 Women	White: 2.8	B
	African American: 7.6	F

http://medicineandpublichealth.vanderbilt.edu/2011WomensHealthReportCard.pdf

2012 County Health Outcomes

Published by the University of Wisconsin's Population Health Institute and the Robert Wood Johnson Foundation, the *County Health Rankings and Roadmaps* are designed to help counties to understand the influences that affect the health and life expectancy of residents.

The *County Health Rankings and Roadmaps* classified the health of counties by ranking them according to the health of county residents. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Davidson County ranked 14th in Health Outcomes, and 26th in Health Factors (with 1st being the healthiest).

The rankings according to the *County Health Rankings and Roadmaps were* designed to analyze multiple measures that affect health, such as the rate of people dying before age 75, high school graduation rates, access to healthier foods, air pollution levels, income, and rates of smoking, obesity and teen births.

The rankings are based on the latest publically available data for each county.

According to the *County Health Rankings and Roadmaps,* the health factors are ranked by multiple elements that affect how well a county is doing. The health factors are determined by the impact that specific issues have on the health of county residents.

Specific issues that cause potential health risks according to the *County Health Rankings and Roadmaps:*

Health Behavior

- Tobacco Use
- Diet and Exercise
- Alcohol Use
- Sexual Activity

Clinical Care

- Access to Care
- Quality of Care

Social and Economic Factors

- Education
- Employment
- Income
- Family and Social Support
- Community Safety

Physical Environment

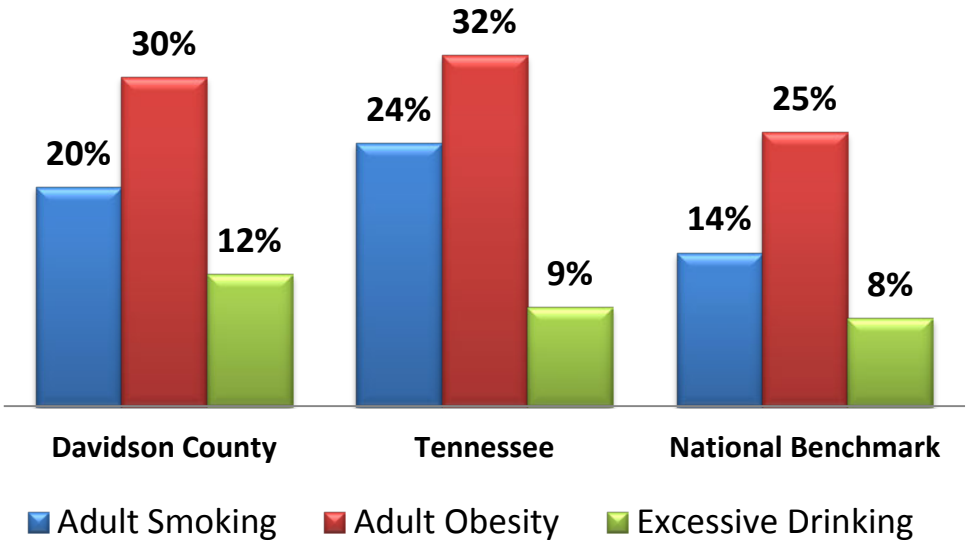
- Environmental Quality
- Built Environment

http://www.countyhealthrankings.org/#app/

Chart HHD-1 shows that Tennessee had a higher ranking in the three areas of adult smoking, adult obesity and excessive drinking when compared to the national target. Davidson County was closer to

the national target for obesity than the state but the county's alcohol consumption at 12% was higher than the state at 9% and exceeded the national benchmark by 4%.

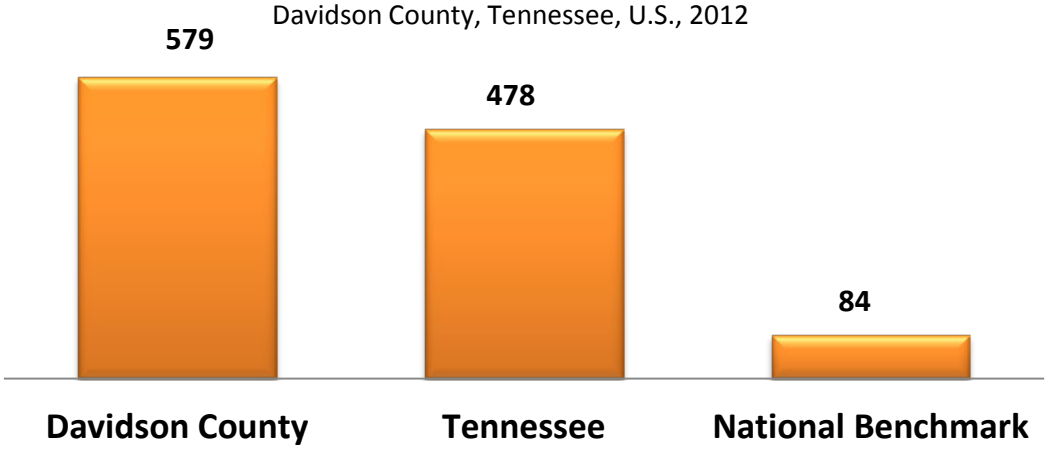
Chart HHD-1: Behavior Health Risks Comparison
Davidson County, Tennessee, U.S., 2012



Source: 2012 County Health Rankings, Robert Woods Johnson Foundation

As shown in Chart HHD-2, in Davidson County, sexually transmitted infections ranked high. In Davidson County, the number of infections was almost 7 times the national benchmark. While Tennessee's infections were also considerably higher than the national benchmark, the benchmark for Davidson County was even higher. Sexual risk behaviors and the lack of sex education were prevalent problems identified by the 2011 Tennessee Youth Risk Behavior Survey and is likely connected to the elevated number of sexually transmitted infections.

Chart HHD-2: Sexually Transmitted Infections Comparison per 100,000 Population
Davidson County, Tennessee, U.S., 2012



Source: 2012 County Health Rankings, Robert Woods Johnson Foundation

Health Outcomes
The health outcomes represents two major factors that if improved could help to contribute to improved health of a county according to the *County Health Rankings and Roadmaps*.

The two major areas of Health Outcomes identified by the *County Health Rankings and Roadmaps* were*:*

- Mortality: Mortality (or death) is the data analysis to determine out how long people live. More specifically, it is the measure of premature deaths (deaths before age 75).

- Morbidity: Morbidity is how healthy people feel while alive. It is the measures of health-related quality of life including physical health, mental health and birth outcomes (babies born with a low birth weight).

Low Birth Weight Babies
According to the section on Maternal, Infant, and Child Health from the Healthy People Initiative there are critical threats to maternal, infant, and child health in the United States. It stated that healthy birth outcomes and early identification and treatment of health conditions of infants are crucial in the prevention of death or disability of infants and children.

Healthy People also described the challenges in reducing the rate of preterm births in the U. S. and in reducing the infant death rate (infant mortality), which in 2011 remained higher than the infant death rate in 46 other countries. Babies with low birth weights are less than 5 pounds, 9 ounces at birth.
www.HealthyPeople.gov

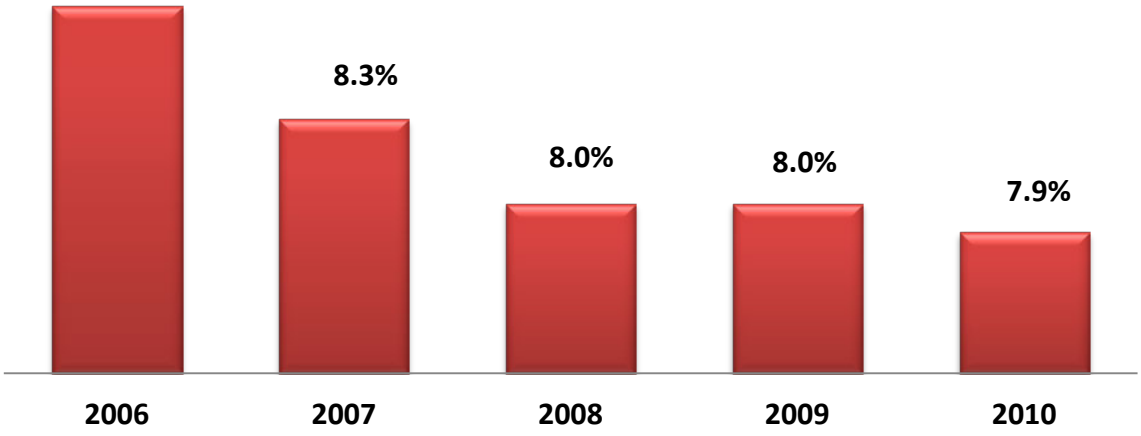
In Davidson County in 2010, there were birth weight disparities in the low birth weight of babies born that year, according to the Tennessee Department of Health's report*, Number of Live Births with Number and Percent of Low Birth Weight, Tennessee, 2010.* It reported that the percentage of black mothers that gave birth to low weight babies (12.8%) was higher than the percentage of white mothers (6.7%). White mothers had a higher percentage of babies born alive (6,247) than the percentage of babies born alive to black mothers (2,883).

In September 2011, the National Institutes of Health analyzed medical records of more than 5 million pregnant women in California. It found a pattern of low-weight births among women who experienced a domestic violence assault. While it did not establish that the violence was the specific cause of the low birth weights, it did identify a correlation. For example, for women who were hospitalized for injuries from an assault during pregnancy, their children weighed an average of 1/3 of a pound each than those who were not hospitalized, with first trimester assaults being associated with the largest decrease in birth weight.
http://www.nih.gov/news/health/sep2011/nichd-08.htm

Infant mortality is the death of a child before the first birthday. According to the Metropolitan Public Health Department 's annual report, released in December 2011, in an effort to reduce the infant mortality rates there were 6,075 home visits provided to at-risk households with education, services, and resources. In September 2012, the Tennessee Commission on Children and Youth's *Infant Mortality* reported that infant mortality accounted for 61% of deaths to Tennessee children. It reported also that Infant mortality rates have decreased consistently since records have been kept and declined by 75% between 1960 and 2000. The pace of progress toward improvement began to slow down after 2000.

As shown in Chart HHD-3, the rate reached 8.7% in 2006 but since then has declined. Prevention and improved health care have helped to decrease the risk of premature births, low birth weight and infant mortality according to the *Infant Mortality* report.

Chart HHD-3: Infant Death Rate
Tennessee, 2006-2010



Source: Tennessee Department of Health, Tennessee Death Rates, 2010

Obesity

According to the U.S. Department of Health and Human Services' National Heart, Lung and Blood Institute, "Reaching and maintaining a healthy weight is important for overall health and can help you prevent and control many diseases and conditions. It also helps to lower your risk for developing these problems, helps you feel good about yourself, and gives you more energy to enjoy life."

As part of its efforts to reverse the childhood obesity epidemic by 2015, the Robert Wood Johnson Foundation, *F as in Fat: How Obesity Threatens America's Future 2011* outlined six policy priorities that were based on evidence from the U. S. Centers for Disease Control, The Institute of Medicine and other research that indicated the following:

- To ensure that all foods and beverages served and sold in schools meet or exceed the most recent Dietary Guidelines for Americans
- To increase access to affordable foods through new or improved grocery stores and healthier corner stores

- To increase the time, intensity and duration of physical activity, in both schools and out-of-school programs
- To increase physical activity by improving the built environment in communities
- To use pricing strategies – both incentives and disincentives – to promote the purchase of healthier foods
- To reduce youth exposure to the marketing of unhealthy foods through regulation, policy, and effective industry self-regulations

Excessive Alcohol Consumption

Excessive alcohol use is associated with a wide range of health and social problems that include acute myocardial infarction, unintended pregnancy, and interpersonal violence according to The Centers for Disease Control and Prevention. According to the U.S. Department of Health and Human Services (HHS) alcohol is a factor in many motor vehicle crashes, falls, burns, accidental drowning, suicides, homicides, sexual assaults, and transfers of sexually transmitted diseases.

The National Center for Chronic Disease Prevention and Health Promotion, *The Power of Prevention Chronic disease: The public health challenge of the 21st century,* 2009 reported that nearly 30% of adult drinkers reported binge drinking in the past 30 days. Adult binge drinkers report an average of 4 episodes of binge drinking per month. It also indicated that nearly 45% of high school students report consuming alcohol in the past 30 days, and over 60% of those who drink report binge drinking (consuming 5 or more drinks on an occasion) within the past 30 days.

Smoking

Lung Cancer was the leading type of cancer for men in the U. S. in 2008, according to the United States Cancer Statistics (USCS) of CDC. It was also the 3rd leading type of cancer of men and women in the U.S. According to the National Cancer Institute, tobacco use has been linked with lung cancer, and other diseases of stroke, head and neck cancer, bladder cancer, heart disease and blood vessel disease. Reducing tobacco use, according to the National Cancer Institute could have a significant impact in reducing the death rates among men and women.

The *2012 Tennessee Men's Health Report Card* revealed that the state has shown a decrease in the number of men that smoke cigarettes but the rate of tobacco use is higher than the national goals of Healthy People 2020 (HP2020). In addition, the death rates from smoking related cancers (lung, head and neck) are two times higher among men in Tennessee than the goals of HP2020.
http://medicineandpublichealth.vanderbilt.edu/TNmenshealthreportcard_2012.pdf
http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41

According to the *2011 Tennessee Women's Health Report Card*, smoking during pregnancy has been linked to childhood health and developmental problems. It also stated that smoking during pregnancy for women increases the risk of premature births and low birth weight babies. http://medicineandpublichealth.vanderbilt.edu/2011WomensHealthReportCard.pdf

According to HHS and the National Center for Health Statistics, tobacco use is the leading cause of premature and preventable death in the U.S., responsible for 443,000 deaths each year because of cigarette smoking and exposure to secondhand smoke. Smoking-related illness in the United States costs $96 billion each year in medical costs and $97 billion in lost productivity due to premature mortality.

In less than 3 months after a person stops smoking, the risk of heart attack begins to decrease, while lung function start to improve, according to The National Center for Chronic Disease Prevention and Health Promotion. It also reported that one year after an individual quit smoking, the risk for heart disease is reduced by half, and 10 years after quitting, the lung cancer death rate is about half that of a current smoker. After quitting for 15 years, the former smoker's risk for heart disease is about the same as that of someone who never smoked.

Smoking is the leading cause of premature preventable deaths in Tennessee, according to the Metropolitan Public Health Department's (MPHD) Health Promotion Division. It initiated a comprehensive effort to reduce tobacco use by youth and to increase the number of smoke-free public places and work places in Nashville. Working with the Smoke-Free Nashville Coalition, it conducted surveys to determine tobacco use by youth and implemented public education campaigns to discourage tobacco use.

Dental

As described in the Children's Dental Health Project (CDC) policy brief, *Cost Effectiveness of Preventive Dental Services,* untreated dental disease can impair the growth and function of children. It can affect their learning ability and their self-esteem, as well as detrimentally affect their ability to eat and to speak. Because dental diseases are progressive and access to preventive care may be limited, dental problems can significantly diminish the general health and quality of life for affected children. This often results in long-term adverse effects that are significant and costly.

The key to reducing the effects of dental problems is through preventive care. The *Cost Effectiveness* policy brief noted that $660 per child in preventative treatment could eliminate the need for emergency dental treatment that could cost ten times that (based on a study of Medicaid reimbursements). Children from low-income families are about half as likely to use preventive dental services as children from middle or high-income families, and are three times as likely to suffer from untreated dental disease.

Dental insurance coverage is related to the use of preventive care. Children with public or private dental coverage are 30% more likely to have received preventive dental care during the past 12 months. According to the CDC's Division of Oral Health, a preventable chronic disease of children is tooth decay. It is experienced by 25% of children aged 6-11 and 59% of those aged 12-19. Also among teens ages 14-17, tooth decay is four times more common than asthma.
http://www.cdc.gov/oralhealth/publications/library/burdenbook/pdfs/CDHP_policy_brief.pdf

In June 2012, the Kaiser Commission on Medicaid and the Uninsured reported that many low-income adults of all racial and ethnic groups had not had a dental visit in the last year. Hispanic adults were least likely to have had a dental visit and were most likely to have gone five years or more without a visit. Hispanic adults were also more likely to have never had a dental visit, including 27% of low-income Hispanic adults. Low-income individuals along with racial and ethnic minorities have been disproportionately affected by tooth decay. Untreated tooth decay affected 26% of adults ages 19-64 with the highest rate among adults living below 100% of the federal poverty level. The rate of untreated tooth decay among African-American adults (39%) and Hispanic adults (41%) was higher than the rates of White adults, which was 22%.

The Metropolitan Department of Public Health provides dental care for children up to age 21, along with limited adult emergency care, using TennCare or a sliding scale. The Dental Sealant program provides preventive dental services to some Metro Nashville Public Schools. According to the Health Department's 2011 Annual Report, the ten-year oral disease prevention initiative in Metropolitan Schools improved the percentage of K-8th grade children who were free of oral disease from 56% in 2001 to 79% in 2010. It also reported that as a result, thousands of children have benefited, by deterring long-term complications of preventable oral diseases.
http://health.nashville.gov/OralHealth.htm

According to Healthy People.gov, Oral Health periodontal (gum) disease, several chronic diseases, including diabetes, heart disease, and stroke have been affected by poor oral health. Also In pregnant women, poor oral health has been associated with premature births and low birth weight.

Breastfeeding

In *The Surgeon General's Call to Action to Support Breastfeeding* (2011), the U. S. Public Health Service report explained that in the last few decades, the rates of breastfeeding improved, but in recent years, there has been slower improvement in the rate of breastfeeding. The U. S. Food and Drug Administration conducted a longitudinal study during 2005-2007 that found that almost half of breastfed newborns also received supplemental formula while still in the hospital (although there was often no medical need for the supplemental formula).

Call to Action also explained disparities in breastfeeding rates that persist by race/ethnicity, socioeconomic characteristics and geography.
http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf

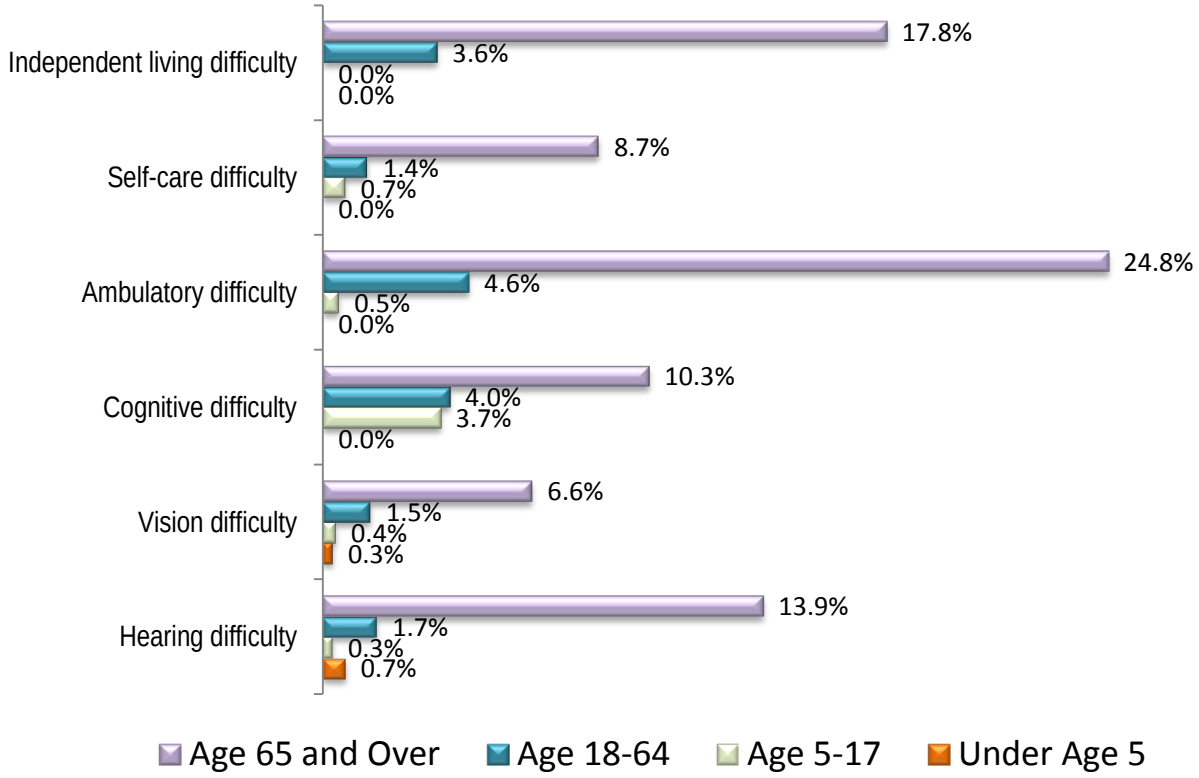
The Tennessee Department of Health has endorsed the Baby Friendly Hospital Initiative, implemented at Vanderbilt's Departments of Pediatrics and Obstetrics and Gynecology. The Baby Friendly Hospital Initiative is a global program that encourages and recognizes hospitals and birthing centers that are committed to breastfeeding and supportive of infant breastfeeding. It is an evidence-based model sponsored by The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). http://pediatrics.mc.vanderbilt.edu/interior.php?mid=4722&news_id=1359 http://www.who.int/nutrition/publications/infantfeeding/9789241594950/en/index.html

Disabilities

The U. S. National Institute of Health defined disability as any physical or mental impairment that substantially limits one or more major life activities. In the United States, there were 57 million people with disabilities according to the U.S. Census Bureau's report, *Americans with Disabilities: 2010.* It also reported that in the U.S. 8% of children under age 15 have disabilities, 21% of people age 15 and older have disabilities, 17% of people ages 21 to 64 have disabilities and 50% of adults ages 65 and older have disabilities.

Chart HHD-4 shows that persons in Davidson County age 65 and over are far more likely to experience the types of specific disabilities. The very low rate of disabilities for children under age 5 may be due to the difficulty in diagnosing some types of disabilities, as well as no expectation that children could live independently or provide self-care.

Chart HHD-4: Percentage with Specific Disabilities by Age Categories
Davidson County, 2011



Source: 2011 American Community Survey

According to estimates in the 2009-2011 American Community Survey 3-Year Summary, those who have disabilities are more likely to be in poverty. The age category with the most significant difference

is 35-64, in which those who have a disability are three times more likely to be in poverty than those who do not have a disability.

Disability Status	Ages 5-17	Ages 18-34	Ages 35-64
With a Disability in Poverty	41.6%	37.6%	29.3%
No Disability in Poverty	27.7%	21.0%	10.4%

Health Access and the Uninsured

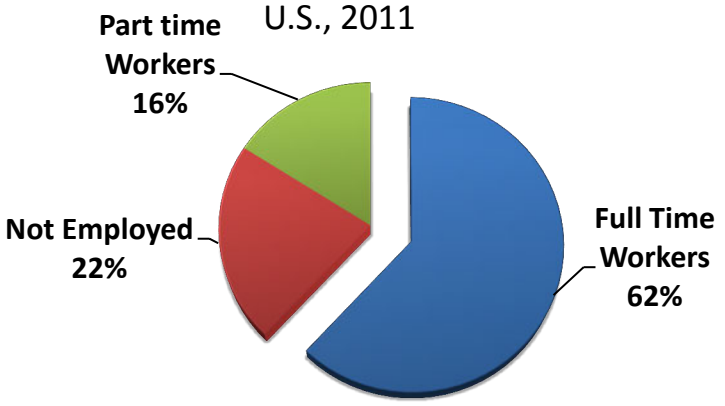
The National Center for Health Statistics (NCHS) released selected estimates of health insurance coverage for the non-institutionalized U.S. population. The data analysis was based on the 2012 National Health Interview Survey. It found that in the first 3 months of 2012, 47.3 million persons of all ages (15.4%) were uninsured at the time of interview, 59.7 million (19.4%) had been uninsured for at least part of the year, and 34.6 million (11.3%) had been uninsured for more than 1 year. Also 6.7% of children under age 18 years were uninsured at the time of interview and of adults aged 19–25, 27.5% (8.2 million) were uninsured.

CDC/NCHS data collected from January-September 2011 from a national sample of interviews with the non-institutionalized population. It found that 28.0% of uninsured adults aged 19–25 delayed medical care or did not obtain care due to cost of the care, and 23.3% delayed medical care due to the additional costs of medical care not covered by limited insurance coverage.

According to the Kaiser Family Foundation's *Five Facts About the Uninsured Population*, released in September 2012, there were 48 million people uninsured in the U.S. under the age of 65. Chart HHD-5 shows that in 2011 most uninsured people under age 65 were full-time workers. *Five Facts* about the Uninsured Population reported workers without insurance coverage, were unable to afford their share of the premium cost or the company did not offer or pay for health insurance. In addition, self-employed workers unable to afford the cost of health insurance were often uninsured.

Chart HHD-5: Uninsured People Under Age 65 by Work Status

U.S., 2011



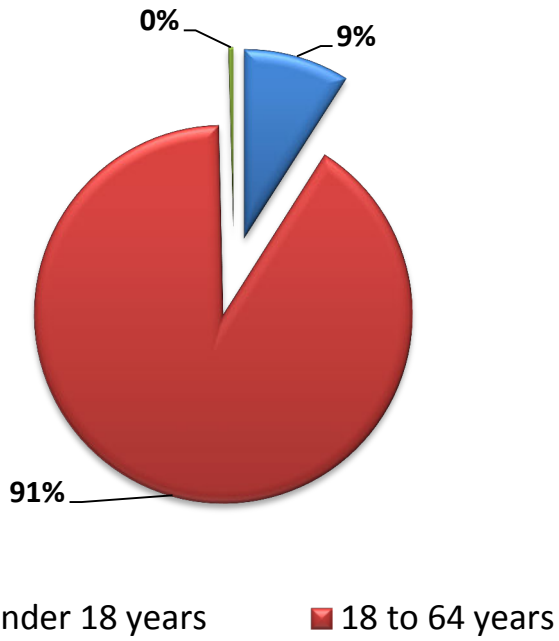
Source: Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, September 2012

Since 2007, the number of uninsured individuals has increased by more than 4.5 million people nationwide, according to Robert Wood Johnson's *State-Level Trends in Employer-Sponsored Health Insurance* (2011).

One of the challenges in health and development is the inequality in health status and access to health care that are more often experienced by low-income individuals, according to *The Measure of America 2010-2011*. The report explained that human development is the process of enlarging the freedom and opportunities of people to improve their well-being. In other words, human development is about the freedom of people to decide who to be, what to do, and how to live quality lives. The National Institute of Child Health and Human Development explained that research shows that adult behavior, intelligence, and motivation are established in the formative years of life, through life experience and human responses. This emphasizes the importance of early life experiences and development.

Chart HHD-6 shows the age groups of the people in Davidson County who do not have health insurance coverage. The group between the ages 18 to 64 was most likely to be uninsured than other age groups. This is likely due to the eligibility of individual's under age 18 for TennCare's TenderCare program or Medicaid eligible individuals, or those 65 and over.

Chart HHD-6: Without Health Insurance by Age Groups
Davidson County, 2011

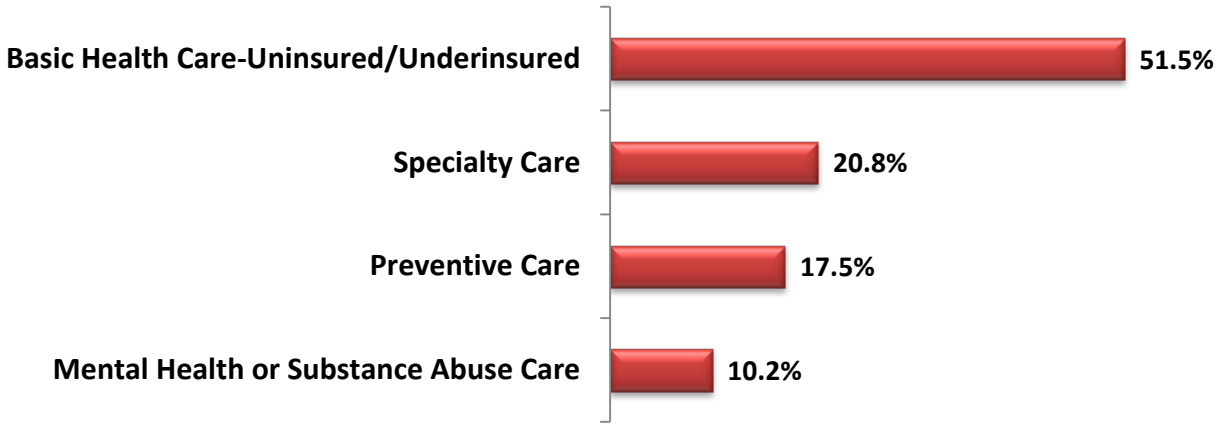


Source: 2011 American Community Survey

Grassroots Community Survey
The Grassroots Community Surveys have been conducted annually since 2009, and questions about health needs were included in 2011 and 2012.

When asked to identify their greatest health related need, respondents indicated that their greatest need was for basic health care coverage for people who had inadequate coverage or no coverage. The second greatest need was the need for specialty care, followed by preventive care and mental health/ substance abuse consecutively, as shown in Chart HHD-7. (Similar information is in Chart LTSS-9 in a subsequent section.)

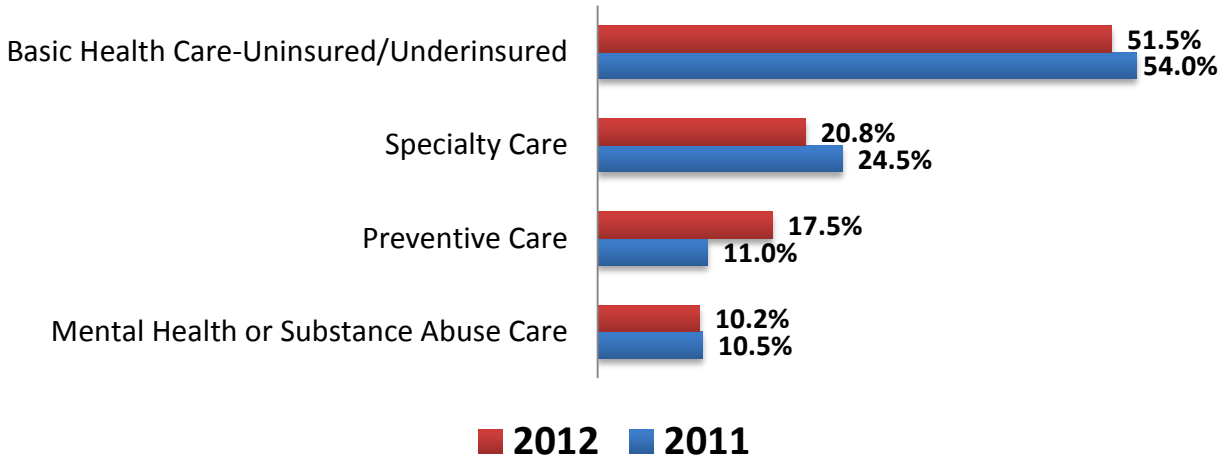
Chart HHD-7: Greatest Need in Health
Grassroots Community Surveys 2012



Source: MSS 2011 Grassroots Community Surveys

Chart HHD-8 shows that the results for the 2011 and 2012 Grassroots Community Surveys were very similar in terms of health needs. In both years, the most frequently identified need was basic health care coverage for the uninsured and underinsured and the second was for specialty care.

Chart HHD-8: Greatest Need in Health
Grassroots Community Surveys 2011-2012



Source: MSS 2011-2012 Grassroots Community Surveys

Update on the Affordable Care Act (ACA)

On June 28, 2012, the United States Supreme Court issued its decision on the constitutionality of the Affordable Care Act (ACA) Medicaid expansion, in National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al. (and related cases, Summary 11-393). An analysis by the Kaiser Commission on Medicaid and the Uninsured (October 2012) explained that the Supreme Court found that the payment required of businesses was a penalty rather than a tax and It would mean that if a state chose not to implement the expansion, the federal government could not withhold federal program funds. The Court's decision focused only on the ACA's Medicaid expansion and other provisions of the law were not affected.
http://www.kff.org/about/kcmu.cfm http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf

According to www.HealthCare.gov web site's *State by State Enrollment in the Pre-Existing Condition Insurance Plan,* as of August 31, 2012, the ACA would expand Medicaid eligibility, beginning in 2014, for people under age 65 who have incomes at or below 138% of the federal poverty level. The Supreme Court ruling on the ACA maintained the Medicaid expansion but it limited the federal authority to enforce it. People who were unable to get health insurance would be eligible for coverage through the Pre-Existing Condition Insurance Plan (PCIP), under the Affordable Care Act.

The *State by State Enrollment in the Pre-Existing Condition Insurance Plan* also reported that the PCIP program would allow health insurance to be available to Americans regardless of a pre-existing health condition. In 2014, all Americans will have access to affordable coverage either through their employer or through new competitive marketplaces called Exchanges, and insurers will be prohibited from charging more or denying coverage to anyone based on the state of their health. As of August 31, 2012, 1513 Tennesseans were granted health coverage because of the PCIP program.

Mental Health Overview

According to Healthy People.gov in *Mental Health and Mental Disorders,* mental health and physical health are interrelated. The ability to maintain good physical health is related to one's mental health stability. It also reported that physical health problems, such as chronic diseases, could significantly impair mental health and decrease the individual's capacity to effectively participate in treatment and recovery.

When individuals are mentally healthy they have the ability to cope more effectively with stress, work productively and maintain healthy relationships according to the National Prevention Council's *Mental and Emotional Well-being,* June 2011. It also stressed that healthy relationships and healthy environments are essential components for the foundation of quality overall health and wellbeing. http://www.healthcare.gov/prevention/nphpphc/strategy/report.html

The U.S. recession caused significant distress for the public mental health system, according to the National Association of Mental Illness, *State Mental Health Cuts: A National Crisis,* 2011. From 2009 to 2011, there were national budget cuts that affected state mental health spending that totaled nearly $1.6 billion dollars that resulted in reduction of vital services for thousands of youth and adults living with serious mental illnesses.
http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=126233

The National Prevention Strategy released on June 16, 2011 by the National Prevention, Health Promotion, and Public Health Council found that there was significant unmet mental health needs among underserved groups that included racial/ethnic minorities, the elderly, low incomes individuals, individuals without health insurance, and residents of rural areas. http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf

The first Surgeon General's report on mental health released in December 1999 entitled *Mental Health: A Report of the Surgeon General* by David S. Satcher, M.D., Ph.D. conveyed important national public awareness of mental health and mental illnesses. It focused on the importance of overcoming stigma, facilitating entry into treatment, and reducing financial barriers to treatment in mental health services. It also stressed the need to increase services and accessibility for minorities and ethnic groups, to ensure mental health coverage for all uninsured individuals, and to implement effective strategies to reduce racial and ethnic disparities.

The report also emphasized that mental disorders are highly disabling for all populations. However, minorities are less likely to receive needed mental health services and are underrepresented in mental health research. Such disparities in mental health services have contributed to a disproportionate number of minorities with mental illnesses that have not fully benefit from needed services. http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf

In 2006, Michael J. Fitzpatrick, Executive Director of NAMI National, National Alliance on Mental Illness, *Grading the States* stated that "Simply put, treatment works, if you can get it, but in America today it is clear that many people living with mental illness are not provided with the essential treatment they need." http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459

Research on the prevention of mental disorders has progressed over the past 20 years, as noted by the Healthy People Initiative. There has been increased research to understand how the brain functions under normal conditions and in response to stressors, as well as knowledge of how the brain develops over time. http://www.healthypeople.gov/2020/LHI/mentalHealth.aspx

Suicide

The Tennessee Suicide Prevention Network (TSPN) of the Tennessee Department of Mental Health and Mental Disorders has described suicide as a major public health problem at both the national and the state levels. According to the Tennessee Department of Health (TDOH) Office of Health Statistics in 2011, there were 938 recorded suicide deaths in Tennessee with the rate of suicide having decreased from 14.7 per 100,000 in 2010 to 14.6 per 100,000 in 2011. In 2010 the state ranked 18th in the nation for suicide, which was an improvement from the prior year of 2009 when the state ranked 9th in the nation.

TSPN reported in *The Status of Suicide in Tennessee, 2012* that In Tennessee youth, suicide among middle-aged and older adults "baby boomers" (ages 55-64) increased since 2002. The Tennessee Department of Mental Health Services reported on suicide in Tennessee, that an estimated 850 men, women, and youth die by suicide each year, more than the number of people who die from homicide, AIDS or drunk driving. The suicide rate in Tennessee is 14.4 per 100,000 individuals, which is higher than the national average of 10.8 per 100,000 individuals, and has situated Tennessee's suicide rate as the 13th highest in the nation.

The annual Tennessee Youth Risk Behavior Survey by the Tennessee Department of Education, found that 25.9% of high school students reported experiencing a period of sadness or hopelessness for two weeks or more that was severe enough to withdraw them away from their usual activities during a twelve-month period, 14.7%, actually considered suicide during that period. One in nine (11.1% of survey respondents) planned how they would do it. One in 16 (6.2%) actually tried to take their own lives. Of those who attempted suicide, approximately 35% of them required medical attention for injuries related to their attempt.
http://www.tn.gov/education/yrbs/index.shtml

Substance Abuse
According to Substance Abuse and Mental Health Services Administration (SAMHSA) substance abuse, addictions, poor emotional health, and mental illnesses create tremendous stress to individuals, families, and communities. "Behavioral health is essential to health, prevention works, people recover and treatment is effective," according to SAMHSA.

According to SAMHSA substance abuse, addictions, poor emotional health, and mental illnesses take a toll on individuals, families, and communities. Individuals and families cannot be healthy without positive mental health and freedom from addictions and abuse of substances, according to the *Leading Changes*, *A Plan for SAMHSA's Roles and Actions, 2011- 2014.* According to the report prevention, treatment, and recovery support services for behavioral health are important parts of health service systems and community strategies that work to improve health status and lower costs for individuals, families, businesses, and governments.
http://www.samhsa.gov/

According to Healthy People, social attitudes and legal responses to the use of illicit drugs and alcohol consumption render substance abuse as a complex public health issues. It also reported that the total costs of substance abuse in the United States, including the loss of productivity, health, and crime-related costs that exceeds $600 billion annually. Family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse, and other crimes are associated with the destructive outcomes of substance abuse that involves drug use and alcohol or both. It also reported that some major public health issues and negative health outcomes that were linked to substance abuse, such as cardiovascular conditions, pregnancy complications, teenage pregnancy, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), sexually transmitted diseases (STDs), domestic violence, child abuse, motor vehicle crashes, homicide and suicide.

Human Development

Human development, particularly child development, is an integral part of health, according to Harvard University's School of Public Health Department-Society, Human Development and Health. It also described how the many aspects of human development consist of social and behavioral effects, as well as the methodologies and interventions used in the study of human development. Although the broad issues of human development include many aspects, this document will primarily focus on child development.

Harvard University's Center on the Developing Child has done extensive research and analysis to understand how genes, life experiences, and the environment interact during the prenatal, child, and adolescent stages of life that influence lifelong outcomes in health, learning, and behavior. Their research revealed that the foundation for a productive, sustainable future is healthy child development.

During the first ten years of life, the child's brain develops at a faster pace than any other time.

Healthy Child Development

Harvard University's Center on the Developing Child's *The Foundations of Lifelong Health Are Built in Early Childhood* report explained how scientific advances in research have suggested that:

- Early experiences are manifested into the human body
- Significant adversity can undermine the body's stress response systems and causes detrimental effects on the brain, immune and cardiovascular systems, and the metabolism.
- The physiological disruptions caused by adversity can persist and could lead to lifelong physical and mental health impairments.

http://developingchild.harvard.edu/index.php/resources/reports_and_working_papers/foundations-of-lifelong-health/

Better Brains for Babies (BBB) developed by the University of Georgia a collaboration of state, local, public and private organizations that promote awareness of early brain development. According to BBB, children's overall development is closely connected to the development of the brain including

physical, social, emotional and cognitive development. It noted that the child's development begins shortly after conception and continues throughout their life.

According to BBB, children learn language through experience. BBB gave the example that when adults and children read the child's favorite book more than once, connections in the child's brain become stronger and more complex. Passively watching television or listening to a recorded story does not have the same impact as conversation. The interaction of conversation is the key experience that signals the brain to develop language.

As described in the Annie E. Casey Foundation's *Double Jeopardy: How Third-Grade Reading Skills and Poverty Influence High School Graduation* (April 2011), the graduation rate is substantially lower for those who lived in poverty. The research found that 22% of children who lived in poverty did not graduate from high school, compared to 6% among those who had never been poor. Black and Hispanic children who were not reading proficiently in third grade were far less likely to graduate than White children.

Double Jeopardy also reported that third grade students who could not read proficiently were four times more likely to drop out of high school than proficient readers. Decades ago, the third grade was recognized as a critical point, during which children "shift from learning to read to reading to learn." http://www.aecf.org/~/media/Pubs/Topics/Education/Other/DoubleJeopardyHowThirdGradeReadingSkillsandPovery/DoubleJeopardyReport040511FINAL.pdf

In 2000 a collaborative team of university faculty, staff, parent educators and researchers at North Dakota State University developed a parenting curriculum that focused on the growth and development of young children. The collaboration resulted in *Bright Beginnings: Understanding and Enhancing Your Young Child's Growth and Development*.

It reported that there are stages of normal child brain development that demonstrates the continued brain development of the child following birth:

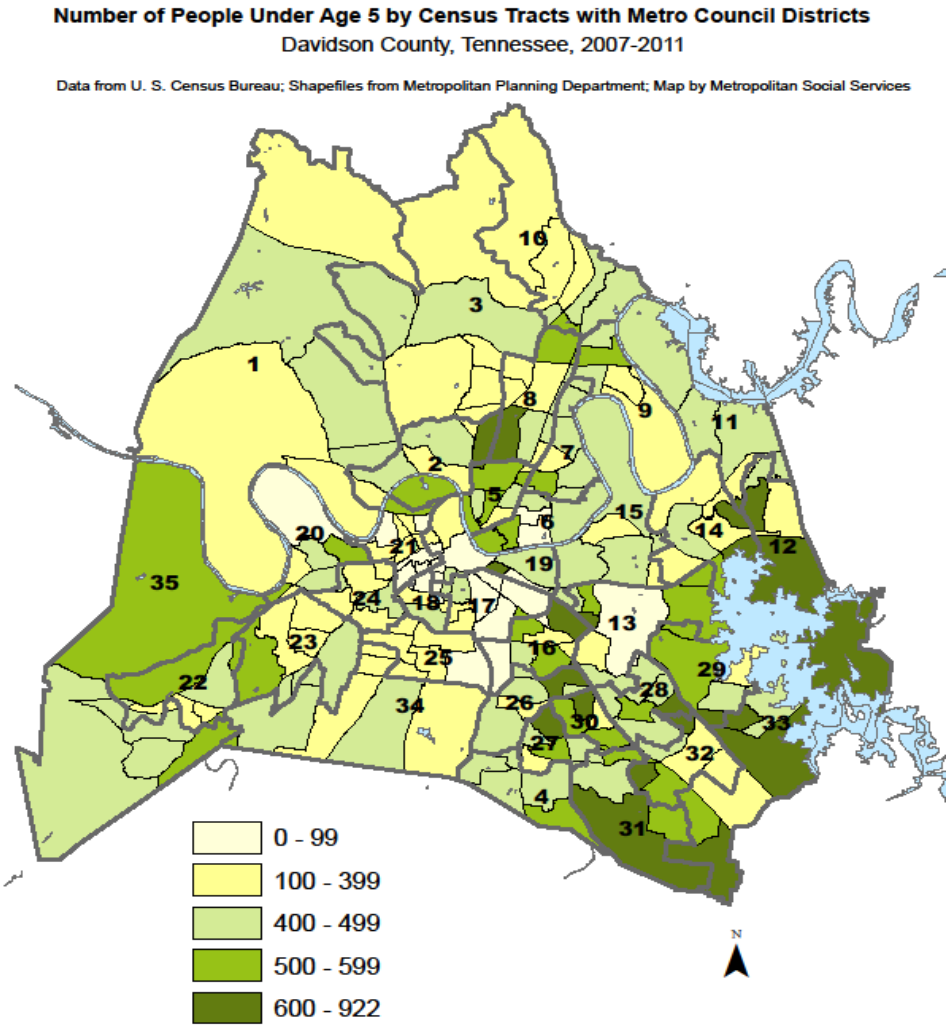
- At 4 months, babies respond to the sounds around them.
- At 8 months, babies can revive past experiences and use them to complete certain task, such as pushing a ball to make it roll.
- At 10 months, babies attempt to utter words in a language familiar to them.
- At 12 months, babies respond differently to the variations in the tones of voice.
- At 18 months, babies develop and store sequences of past events. They can revive memories of past activities.
- At 24 months, preschool children can remember the faces of people with whom they are more familiar.
- At 30 months, children develop spatial maps in their mind and remember where things are located.
- At 36 months, children are able to distinguish between various emotions, such as anger or happiness.

Extensive research has shown that infants who are breast-fed by their mothers experience multiple benefits that contribute to the infant's healthy development, according to the American Academy of Pediatrics. According to the American Dietetic Association, the nutrition of DHA an omega-3 fatty acid found in breast milk can provide nutrients to the child's brain and nervous system.

The Women, Infants and Children (WIC) program for low-income women, infants and children a federally funded program has been involved in education on the benefits of breast-feeding and has been recognized for their efforts by the Tennessee Department of Health. According to the Tennessee Department of Health, the benefits of breast-feeding will contribute to the improvement of health outcomes for babies in Tennessee.

The geographic pattern of where those under age 5 live in Davidson County varies. However, most of the census tracts with the highest number of children under age 5 are in the southeast quadrant of Davidson County. The map below shows the number under age 5 by Census Tracts and includes the Metropolitan Council Districts.

Source: 2007-2011 American Community Survey 5-Year Summary



Child Care

The American Academy of Pediatrics (AAP), the American Public Health Association (APHA), and the National Resource Center for Health and Safety in Child Care and Early Education (NRC) released the 3rd edition of Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs in 2011. It provided quality health and safety practices and policies that should be followed in quality child care and education settings, pointing out that the most crucial issues in a child's development are health, education and quality of child care.

High quality child care is an essential work support for working parents in their capacity to maintain employment, according to the U.S. Department of Health and Human Services (HHS). It also noted that the high cost of child care could be a deterrent for many low-income families who cannot afford to pay for child care without financial assistance.

The Center for the Research on Women at the University of Memphis reported that quality child care is an investment in the future of the U.S. According to their research, *Child Care as an Investment for the Future,* June 2012, "With the increase of poverty among female headed families, maintaining access to stable, and affordable, high quality child care is imperative to sustaining employment and economic security." It also reported that, "Investing in child care has the potential to create jobs in child care for low-income women, allow parents to seek employment outside the home, raise household income, stimulate local economies, boost tax revenues, and improve child development."

In April 2011, Mayor Karl Dean's Advisory Council on Early Childhood Development and Early Education submitted a report that described the patchwork of services in Davidson County. It provided recommendations that could improve outcomes and quality for young children, their families and Nashville in early childhood development and education (described in additional detail in the 2011 Community Needs Evaluation on pages 59-60).
http://www.nashville.gov/mocy/docs/EarlyChildhoodReport_110413.pdf

The Tennessee Department of Human Services (DHS) licensing process for child care providers is designed to ensure the health and safety of children. The Department of Human Services is legally responsible for licensing child care centers with 13 or more children. All child care programs including Tennessee Voluntary Pre-K (TN-VPK), Head Start, and community-based child care programs are required to meet DHS licensing standards. Not all programs have achieved the DHS star rating because of the high quality standards. DHS maintains the 3-star rating systems as the standards for the licensing process to demonstrate program quality.
http://www.tn.gov/humanserv/adfam/cc_main.html

The U. S. Department of Health and Human Services Office of Child Care (OOC) administers the Child Care and Development Fund (CCDF) providing oversight of state government to ensure support for

children and their families in accessing quality child care to meet their needs and to prepare children to succeed in school. To support CCDF services, the OCC develops the standards, and policies, as well as provide guidance and technical assistance to states to administer CCDF programs. It also provides funding to improve the quality of care to be used for healthy child development, child care licensing, quality improvements systems to meet higher standards, and for child care workers to attain further training and education.

The CCDF has provided states the opportunity to build Quality Rating and Improvement Systems (QRIS), which set voluntary higher standards for child care and provide financial incentives and technical assistance to meet standards.

The Tennessee Department of Human Services (DHS) Tennessee's Child Care Certificate Program (CCCP) is funded by the Child Care Development Block Grant (CCDBG) and the federal The Temporary Assistance for Needy Families (TANF) Block Grant.

According to the Tennessee Department of Human Services, during fiscal year 2011-2012, there were 35,101 children enrolled in quality child care facilities in which child care costs were subsidized.

DHS eligibility requirements to participate in the Child Care Certificate Program include:

- Families in the Families First Program who need help paying for child care
- Parents that are no longer eligible for Families First but need assistance to pay for child care as they transition from welfare to work
- Teen parents
- Children at risk as determined by the Tennessee Department of Children Services (DCS)

http://www.tn.gov/humanserv/adfam/cc_olm/2.1EligibleChildren.htm

Grassroots Community Surveys

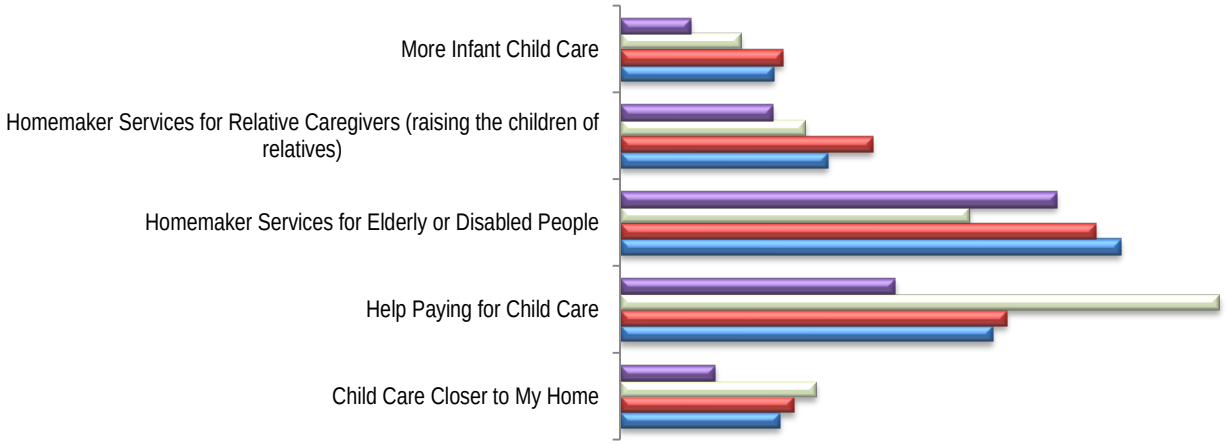
The Grassroots Community Surveys have been conducted annually since 2009. The 2012 survey included a question asking respondents to identify their greatest need in the category of Home and Community Based Services (HCBS). In that category, there were 3 questions that related to child care. The greatest need identified by respondents in relations to child care was the need for help to pay for child care.

The responses to the 3 child care related questions varied over the years 2009, 2010, 2011, and 2012 as shown in Chart HHD-1, It also showed that there was greater percentages of need for help to pay for child care was, care closer to home and for infant care in 2011 than in 2012. The trend seemed to indicate improvement that could be attributed to improved access and availability of child care.

Chart HHD-1: Greatest Need in Home and Community Based Services

(Seniors, Child Care)

Grassroots Community Survey, 2009-2012



	Child Care Closer to My Home	Help Paying for Child Care	Homemaker Services for Elderly or Disabled People	Homemaker Services for Relative Caregivers (raising the children of relatives)	More Infant Child Care
2012	6.5%	19.0%	30.1%	10.5%	4.8%
2011	13.52%	41.30%	24.07%	12.78%	8.33%
2010	12.0%	26.7%	32.8%	17.4%	11.2%
2009	11.0%	25.7%	34.5%	14.3%	10.6%

Source: 2009-2012 Grassroots Community Surveys

Education and Human Development

Ready Nation, a project of America's Promise Alliance, released *Savings Now, Savings Later* in September 2012 that examined the economic savings of investing in early childhood programs. The brief reported that the benefits of quality early childhood programs are realized beyond elementary school. Also by third grade, children who have participated in high-quality pre-kindergarten averaged better standard test scores, lower grade retention rates, and fewer special education placements when compared to their peers who did not participate in such programs.

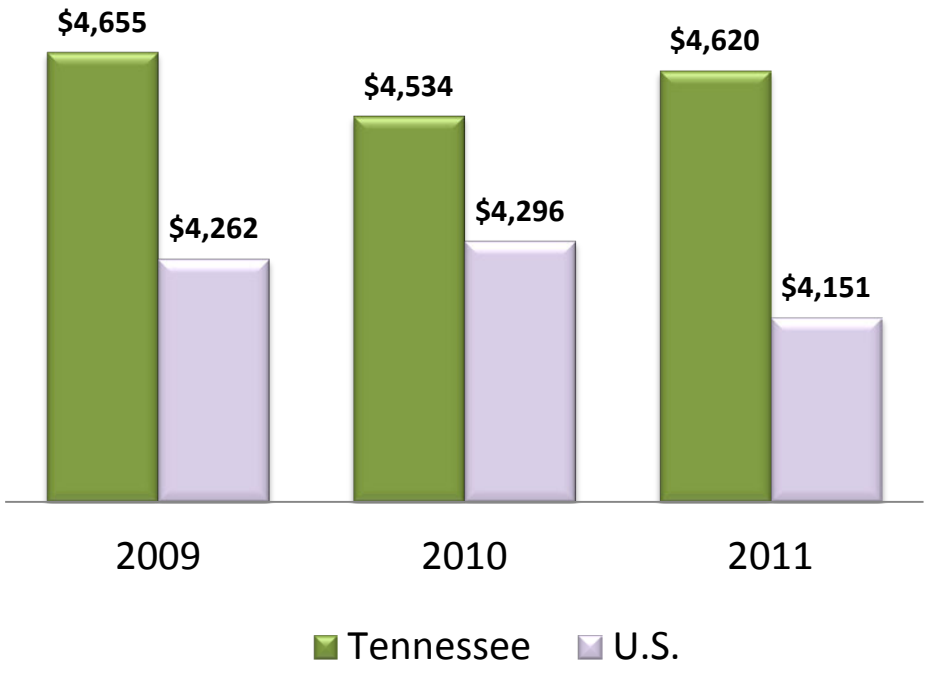
According to the Brookings Institute's *Starting School at a Disadvantage: The School Readiness of Poor Children,* March 2012, in the U.S. children who are poor start to school at a disadvantage because of inadequate educational skills and health development. It reported that by age five, only about 48% of

poor children are ready for school compared to 75% of children from families with moderate to high incomes.

Starting School at a Disadvantage also reported that in addition to poverty, a child's school readiness was influenced by preschool attendance, the parents' education, maternal depression, prenatal exposure to tobacco, and low birth weight. The probability of being school ready is 9% higher for children who attend preschool. Also being ready for school was 10% lower for children whose mothers smoked during pregnancy and 10% lower for children whose mothers were not supportive and nurturing during parent-child interactions. http://www.brookings.edu/~/media/research/files/papers/2012/3/19%20school%20disadvantage%20isaacs/0319_school_disadvantage_isaacs.pdf

The National Institute for Early Education Research at Rutgers University has surveyed the nation's state preschool programs since 2001. The *2011 State of Preschool Yearbook* reported that the total state funding for U.S. Pre-K programs decreased by nearly $60 million from the 2010 school year. Tennessee had shown commitment through increased funding and standards for preschool education according to the *2011 State of Preschool Yearbook.* The average state funding in Tennessee for each child enrolled in Pre-K exceeded the national average as shown in Chart HHD-2.

Chart HHD-2: Spending Per Child Enrolled in Pre-K
Tennessee and U.S., 2011



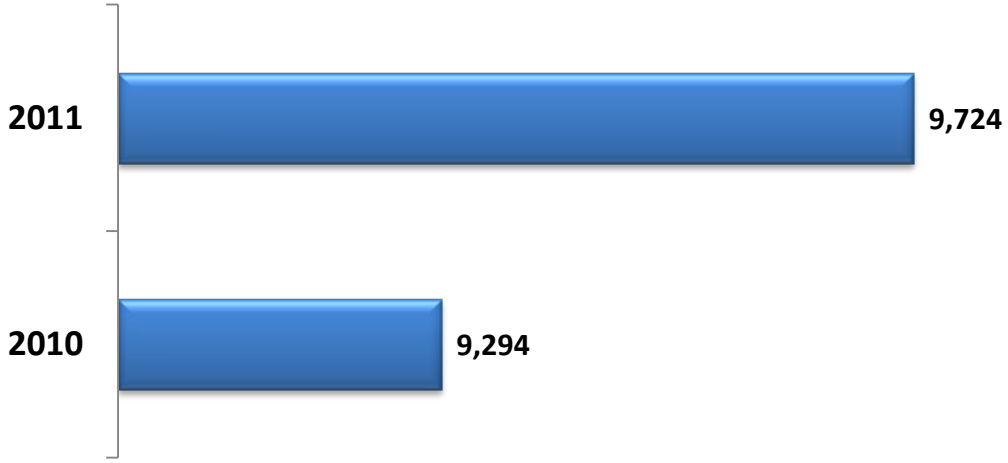
Source: National Institute for Early Education Research

In the state of Tennessee during the 2010-2011 school year, 18,453 children were enrolled in the state's Voluntary Pre-K program with 934 classrooms across the state, with at least one classroom in every school district in the state.

The U. S. Census definition of preschool/nursery school encompasses children in Head Start, Pre-kindergarten (Pre-K) and all programs that provide preschool education preceding kindergarten.

Chart HHD-3 shows an increase for enrollment for preschool/nursery school increased in Davidson County from 2010 to 2011.

Chart HHD-3: Preschool Enrollment in Davidson County
2010, 2011



Source: 2010-2011 American Community Surveys

The *2011 Education Report Card* is the Nashville Chamber of Commerce's annual education report card of Metropolitan Nashville Public Schools (MNPS), 2010-2011 school year. It is an in-depth assessment of the most recently completed school year to evaluate overall academic performance and achievements. According to the 2011 Education Report Card, the overall academic achievement was low in MNPS.

> Research shows that students who are proficient readers by third grade are more likely to be successful later in school and in life. Third-grade reading skills were reported to be a strong predictor of high school graduation and college attendance.

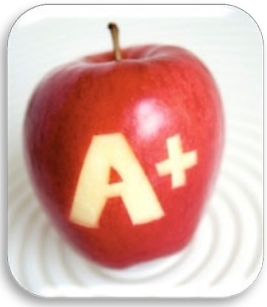
The 2010-2011 school year was the second year for students to be tested on new state standards, and the second year that every Tennessee student in a graduating class took the ACT (American College Testing), according to the 2011 Education Report Card. When MNPS was compared to its surrounding

counties and the other large public school systems across the state (other than Memphis City Schools), MNPS were substantially lower in the percentage of students who were proficient in grades 3-8 math and reading.

At the high school level, less than a third of the Class of 2011 met the minimum definition of college and career readiness, by scoring at least 21 or greater on the ACT exam. The most important performance measurement is the ACT score, in lieu of an exit exam that predicts college and career readiness for Metro Schools graduates. http://www.nashvillechamber.com/Libraries/Education_Reports_and_Publications/2011_Education_Report_Card.sflb.ashx

The Tennessee Department of Education (TDOE) has developed a statewide accountability system following a federal approval waiver in 2012 that allowed the state to replace the federal program No Child Left Behind. The waiver according to TDOE allowed the state to continue to improve, accomplish its own developmental goals, and accountability measures, or Adequate Yearly Progress (AYP). The APY system was created to align with the state's goal to become the fastest-improved public school system in the nation.

"As Tennessee's second largest school district, Metropolitan Nashville Public Schools (Metro Schools) is responsible for ensuring that more than 76,000 students in 140 schools are being prepared every day for college, a career and life," according to Achieving Student Success through Effective Teaching (ASSET). ASSET is MNPS's plan to attract, cultivate and retain the most talented educators.
http://www.mnps.org/Page68384.aspx



Special Needs in Public Education

Federal laws protect the rights of children with special needs so they can receive additional services or accommodations to attend public schools. Federal law mandates that every child receive a free and appropriate education in the least restrictive environment possible. The mandate is supported by Federal laws that apply specifically to children with special needs:

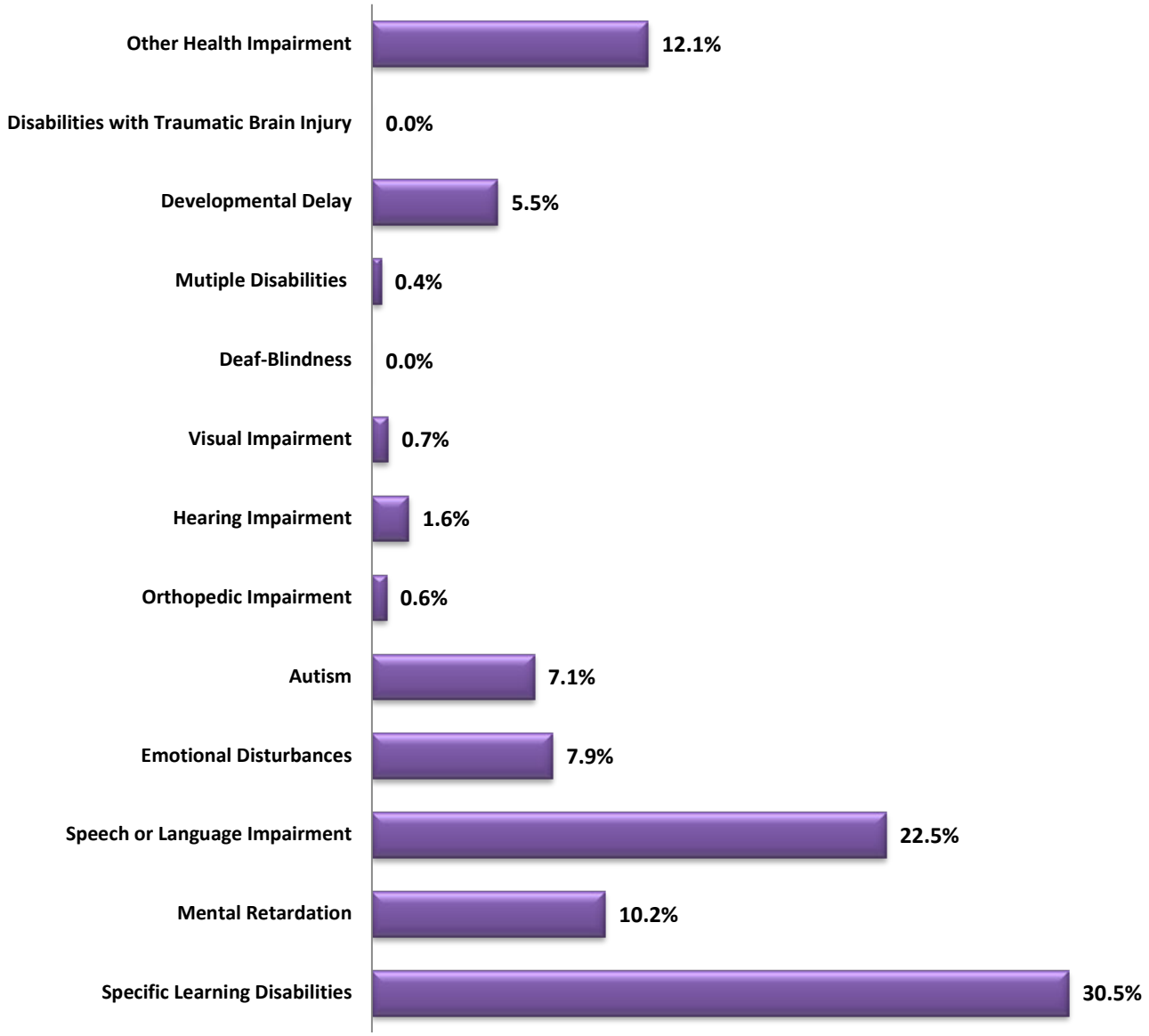
- The Individuals with Disabilities Education Act (IDEA) (1975) - IDEA is a federal law (1975, amended by the Office of Special Education Programs in 1997) that governs all special education services for children in the United States.

- Section 504 of the Rehabilitation Act of 1973 -Section 504 is a civil rights statute (1973) that requires schools to not discriminate against children with disabilities and provide them with reasonable accommodations. It covers all programs or activities, whether public or private, that receive any federal financial assistance.

- The Americans with Disabilities Act (ADA) (1990) -The ADA (1990) requires all educational institutions, other than those operated by religious organizations, to meet the needs of children with psychiatric disorders. The ADA prohibits the denial of educational services, programs or activities to students with disabilities and prohibits discrimination against all such students.

According to the Tennessee Department of Education, in 2011, Metropolitan Nashville Public Schools had 9,001 students with disabilities. Chart HHD-4 shows the specific types of disabilities for those students.

Chart HHD-4: Children and Youth with Disabilities in Public School
Metro Nashville Public Schools, 2011



Source: Tennessee Department of Education, 2011 TDOE Report Card

Public Education for Homeless Students

According to the National Center on Family Homelessness, children living without permanent, long-term housing are considered at risk because of the extreme stress it causes children and families and the damage it can cause to children's development. The federal McKinney-Vento Homeless Assistance Act ensures educational rights and protections for children and youth experiencing homelessness. The term homeless has been defined by the McKinney-Vento Act's Education for Homeless Children and Youth Program as "a lack of permanent housing resulting from extreme poverty, or, in the case of an unaccompanied youth, the lack of a safe and stable living environment." http://center.serve.org/nche/downloads/mv_full_text.pdf

According to MNPS's Homeless Education Resources Outreach (HERO) program for families in transition, during the 2011-2012 school year there were 2,495 students enrolled in Metro Schools who met the McKinney-Vento definition of homelessness. There were 1,163 homeless students in elementary schools, 733 in middle schools and 599 in high school, plus 283 preschool aged siblings ranging from birth to age 4. It is projected that there could be 2,500 or more students who will be homeless at some time during the 2012-2013 school year.

The United States Mayors Conference's 2011 *Hunger and Homelessness Survey* reported that in 2011 29 Tennessee cities received $1,227,251 from a total national allocation of $65,296,146 from the McKinney-Vento Homeless Children and Youths program. The McKinney-Vento Homeless Children and Youth Program is administered through the U.S. Department of Education. The program's purpose is to ensure that all homeless children and youth have equal access to enroll and attend public schools, and to receive the same free public education as all public school students.

The total number of homeless families with children had increased by 10% in 2011 with an estimated 30% demand for emergency shelter for families and children that could not be met, according to The United States Mayors Conference's 2011 *Hunger and Homelessness Survey.*

The National Center on Family Homelessness updated report, *America's Youngest Outcasts: State Report Card on Child Homelessness for 2010* identified the overall rankings for the comparative performance of states in addressing homelessness. Tennessee's ranking has worsened in recent years, likely due to the increased number of homeless children and families in the state.

According to the latest available data from The National Center on Family Homelessness out of all states, Tennessee was ranked 24th in 2000, 34th in 2006 and 39th in 2007.
http://www.homelesschildrenamerica.org/media/NCFH_AmericaOutcast2010_web.pdf

Housing and Neighborhoods

Key Findings

- **Housing and Related Assistance remains the greatest need category cited by respondents in Metro Social Services Grassroots Surveys.**
- **In 2011, 32% of calls to United Way's 2-1-1 Call Center were for Housing and Utilities.**
- **The number of foreclosures in Davidson County is down in 2011 from the annual numbers for 2008-2010.**
- **The number of new building permits for privately-owned residential buildings for Davidson County has started to increase.**
- **Home sales in the Greater Nashville Region have increased from 2010-2012, and condominium sales started increasing in 2011.**
- **While the number of Davidson County homeowners with a cost-burden has trended downward since 2008, the number of cost-burdened renters has trended upward.**
- **The percentage of high-interest loans for residents of predominately minority-race neighborhoods was more than double that of other neighborhoods.**
- **In 2012, the Nashville Metropolitan Statistical Area (MSA) homeless rate was reported as 14 per 10,000 people in the general population, ranking 40th among the 100 largest U. S. MSAs.**

> **Do not presume, well-housed, well-warmed, and well-fed, to criticize the poor.** (Attributed to Herman Melville)

Introduction and Demographics

The U. S. Census Bureau defines housing unit as a house, apartment, mobile home, group of rooms or single room that is occupied or intended for occupancy as separate living quarters.

As shown in the table, there were 285,027 total Davidson County housing units in 2011 with 106,995 of those being multi-unit structures.

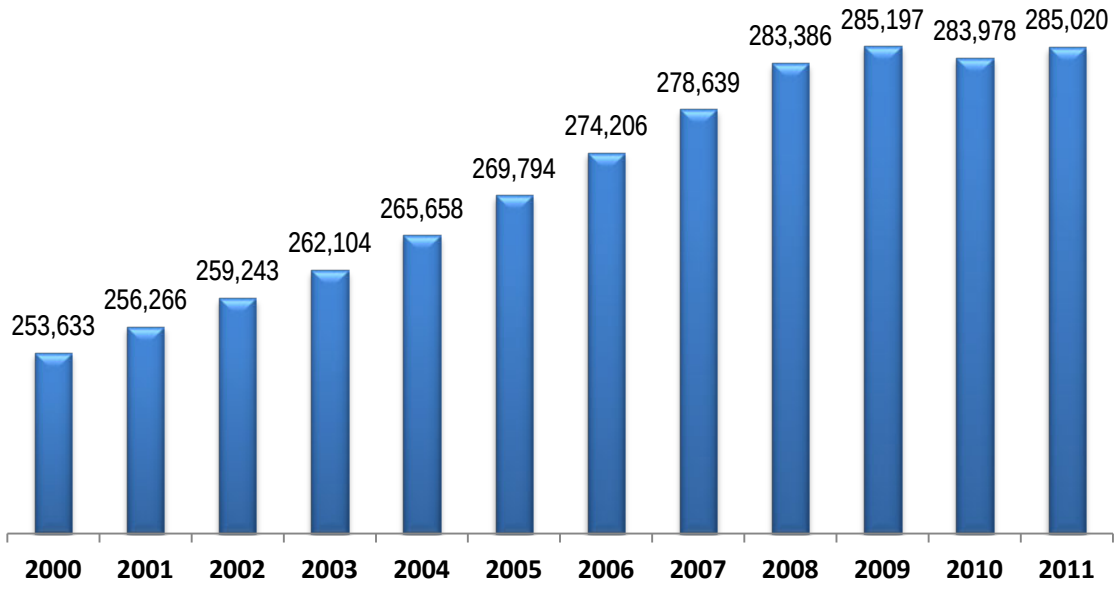
Housing Units by Type - Davidson County, 2011

Davidson County	Estimate	Percentage
Total Units:	285,027	
1, detached	147,324	51.7%
1, attached	25,762	9.0%
2	15,084	5.3%
3 or 4	9,640	3.4%
5 to 9	19,061	6.7%
10 to 19	26,837	9.4%
20 to 49	17,340	6.1%
50 or more	19,033	6.7%
Mobile home	4,946	1.7%
Boat, RV, van, etc.	0	0.0%

Source: 2011 ACS Table B25024: Units In Structure

Chart H-1 shows the trend in the total number of existing housing units in Davidson County, reflecting increases until 2009, followed by a small decrease for 2010 and then a slight increase for 2011 almost to the 2009 level.

Chart H-1: Number of Housing Units
Davidson County, 2000-2011



Source: Census Population Division - Annual Estimates of Housing Units for Counties in Tennessee, ACS Table B25001 Housing Units and ACS Table DP04 Selected Housing Characteristics.

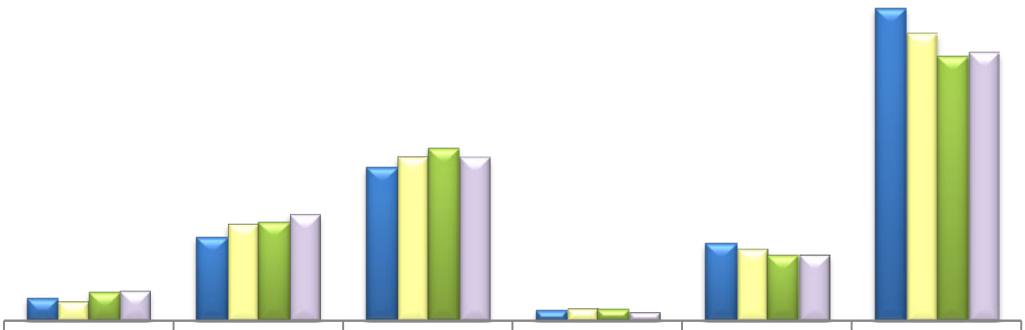
According to the American Community Survey, overall home ownership in Davidson County in 2011 was 57.6%. Of the 254,655 occupied housing units, 53.9% were owner-occupied and 46.1% were renter-occupied. Renters moved more frequently than homeowners, possibly because it is easier to

move if renting than if owning, especially in a distressed housing sales situation. Of Davidson County's owner householders in 2011, 91% lived in the same house one year ago. Of renters, 64% lived in the same house one year ago. Householder refers to the person in whose name the housing unit is owned or rented. The "reference person" is the Householder, to whom the relationship of all other household members is reported in the American Community Surveys.

There are several benefits to home ownership. Homeowner families generally experience a greater level of stability, which could contribute to social benefits (civic engagement, social alliances, etc.). In recent years, the burst of the housing bubble combined with the recession temporarily negated the previous financial benefits of homeownership for some. However, historically the purchase of a home was an opportunity for a family to build equity and add assets. Owning a home continues to be part of the American Dream for many, and the financial advantages are being restored as the economy recovers.

As shown in Chart H-2, there were more people renting in 2011 than in 2008, and fewer people owning in 2011 than in 2008, influenced by factors such as the housing crisis and unemployment.

Chart H-2: Trends in Ownership and Rentals by Race/Ethnicity
Davidson County, 2008-2011



	Hispanic Renter	African-American Renter	White Renter	Hispanic Owner	African-American Owner	White Owner
2008	8,616	32,675	59,741	4,068	30,035	121,814
2009	7,758	37,986	63,930	5,007	28,225	111,795
2010	11,016	38,300	67,304	4,673	25,604	102,855
2011	11,878	41,607	63,868	3,558	26,012	104,521

Source: 2011 ACS, Table B25003

During the recent economic downturn, the number of multigenerational households increased, for reasons such as adult children moving in with parents (or vice-versa), reluctance of younger people to establish a household during hard economic times, etc. The AARP Public Policy Institute reported that

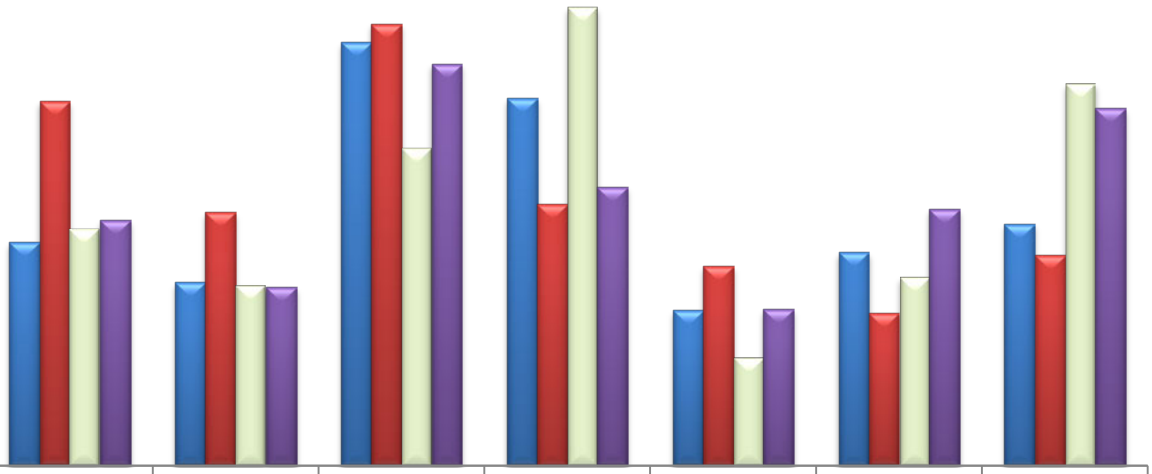
nationally from 2007 to 2010, the share of adults aged 20–29 who were heads of household in the U. S. fell more than 2%. The 2009-2011 American Community Survey estimates that 5.4% of Tennessee households were multigenerational. The latest estimate available for Davidson County is for 2010, showing 8,994 (3.4%) households with three or more generations.
http://assets.aarp.org/rgcenter/ppi/econ-sec/fs221-housing.pdf
http://www.census.gov/prod/2012pubs/acsbr11-03.pdf

Housing Needs

Chart H-3 shows ratings from the MSS Grassroots Survey by community respondents for 2009-2012. In 2012, Help Paying Utility Bills was rated as the greatest need within the Housing area (21.4%), followed by Section 8 Vouchers and then Help with Rent Payments.

For all years except 2011, the need for Help Paying Utility Bills was the highest among need categories for Housing and Related Assistance. In 2010 and 2011, there was a significant increase in the identification of the need for Section 8 Vouchers.

Chart H-3: Greatest Need in Housing and Related Assistance
Grassroots Community Survey, 2009-2012



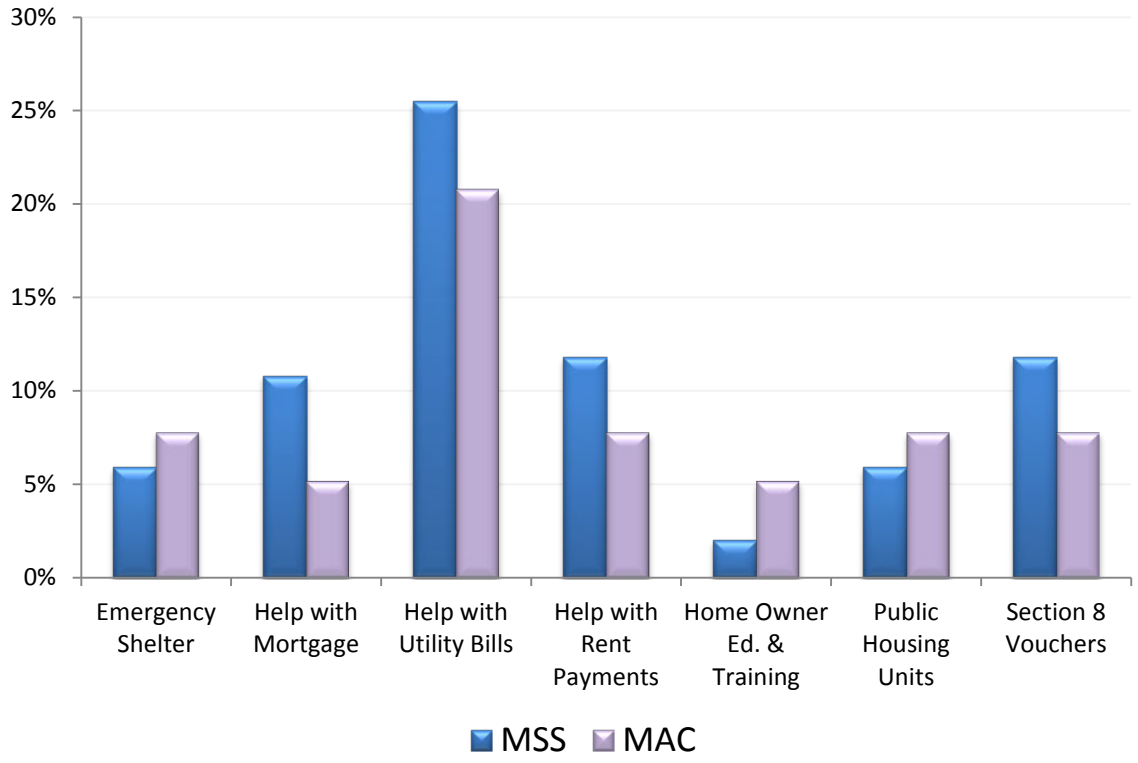
	Emergency Shelter	Help Paying Mortgage Payments	Help Paying Utility Bills	Help with Rent Payments	Homeowner Education and Training	Public Housing Units	Section 8 Vouchers
2009	11.9%	9.8%	22.6%	19.6%	8.3%	11.4%	12.9%
2010	19.4%	13.5%	23.6%	14.0%	10.6%	8.1%	11.2%
2011	12.7%	9.7%	17.0%	24.5%	5.8%	10.1%	20.4%
2012	13.1%	9.5%	21.4%	14.9%	8.3%	13.7%	19.0%

Source: 2009-2012 Metro Social Services Grassroots Community Surveys

Chart H-4 compares the responses from customers of Metro Social Services (MSS) customers and Metro Action Commission (MAC) customers for Housing. Similar to survey results for all community

respondents, Help with Utility Bills was number one for both groups with Section 8 Vouchers and Help with Rent Payments ranking highly. MSS reports that they received 218 requests for housing help from July 1, 2011-June30, 2012, and were able to assist 134 clients to obtain or maintain housing.

Chart H-4: MSS and MAC Client Grassroots Survey Responses
Davidson County 2012



Source: Metro Social Services Grassroots Community Surveys

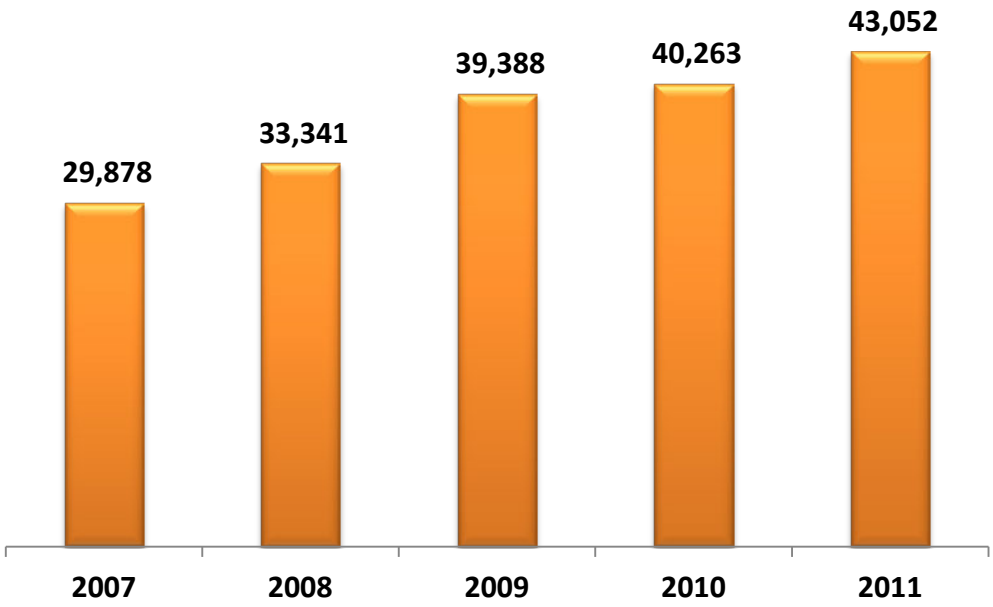
In December 2012, the local Continuum of Care's homeless services provider subcommittee (GAPS) reported the results of their survey of 23 local housing agencies about housing needs. The top three housing needs cited were the following:

- Access /Transportation/Bus Passes
- Job Placement
- Permanent Affordable Housing

The number of inquiries to the United Way's 2-1-1 Call Center for Middle Tennessee about Housing and Utilities continues to outnumber calls for any other type of need. From 2007 through 2011, the annual average percentage of all 2-1-1 calls for housing/utilities has remained generally consistent at 31.8% for 2007, 27.0% for 2008, 25.9% for 2009, 26.3% for 2010, and 28.9% for 2011.

Chart H-5 shows that the actual number of calls for housing/utilities has increased each of the last five years.

Chart H-5: Number of Calls to 2-1-1 for Housing/Utilities
Davidson County 2007-2011



Source: United Way of Metropolitan Nashville

Housing Market

Several sources indicate cautious optimism that the housing market is beginning to recover, with fewer foreclosures and more home sales. On September 21, 2012, the Brookings Institution's *How Bright is the Housing Bright Spot* notes that there have been slight gains in national home sales and prices, and in new home construction. A general reduction in the number of foreclosures, combined with increasing sales presumably indicates a turn-around in the housing market.
http://www.brookings.edu/blogs/up-front/posts/2012/09/21-housing-dynan

In *Recovering But Not Recovered,* CoreLogic reported that through September 2012, U. S residential investment grew at about 14%. A CoreLogic *Foreclosure Report* shows a decline in the foreclosure rate for the Nashville MSA from 1.9% in October of 2011 to 1.24% in October 2012.
http://www.corelogic.com/downloadable-docs/marketpulse_2012-november.pdf
http://www.corelogic.com/about-us/researchtrends/national-foreclosure-report.aspx#

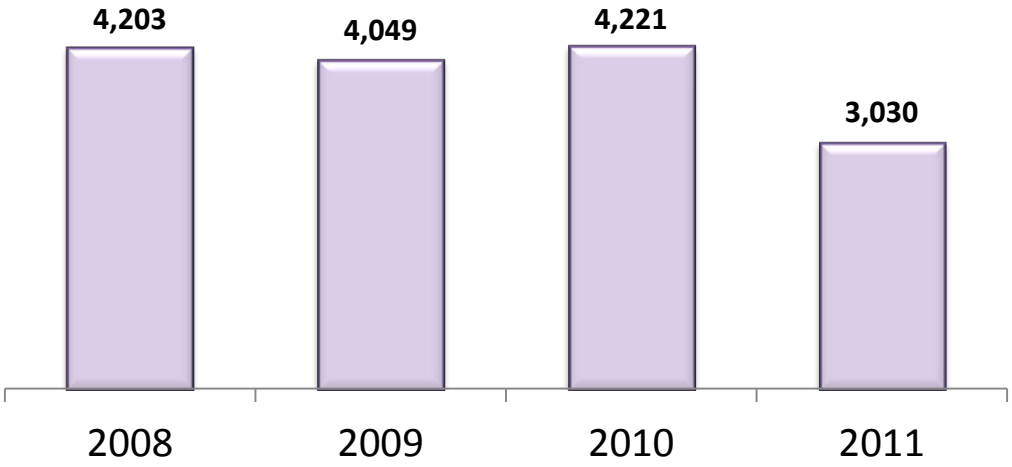
HUD and the U.S. Department of the Treasury's housing health scorecard of key housing market indicators for October 2012 show national homes prices and existing and new home sales are trending upward, but have not recovered yet to the levels of 2007.
http://portal.hud.gov/hudportal/documents/huddoc?id=oct_natl_2012_sc.pdf

MPF Research, a real estate research firm specializing in apartment market dynamics, reported in *Apartment Market Report – Nashville, Tennessee*, that as of the end of the 3rd quarter of 2012, apartment occupancy in the Nashville MSA was 95.8%, almost at a pre-recession level. The average apartment occupancy growth in Davidson County was 6.7%.
https://www.realpage.com/apartment-market-research/nashville-apartment-trends/

In June 2012, the Joint Center for Housing Studies of Harvard University's *State of the Nation's Housing 2012* explained that the slow recovery is due to several factors. These include the continuing loans in foreclosure and continued higher distressed sales which tend to keep prices lower, and the number of home owners who are "under water" owing more on their loans than their homes are worth on the current market, which tends to depress home sales. The number of vacant homes continues to be high, reducing the demand for new construction.
http://www.jchs.harvard.edu/research/publications/state-nation%E2%80%99s-housing-2012

As described above, Davidson County saw a reduction in the number of foreclosures in 2011, as seen in Chart H-6.

Chart H-6: Annual Foreclosures
Davidson County, 2008-2011



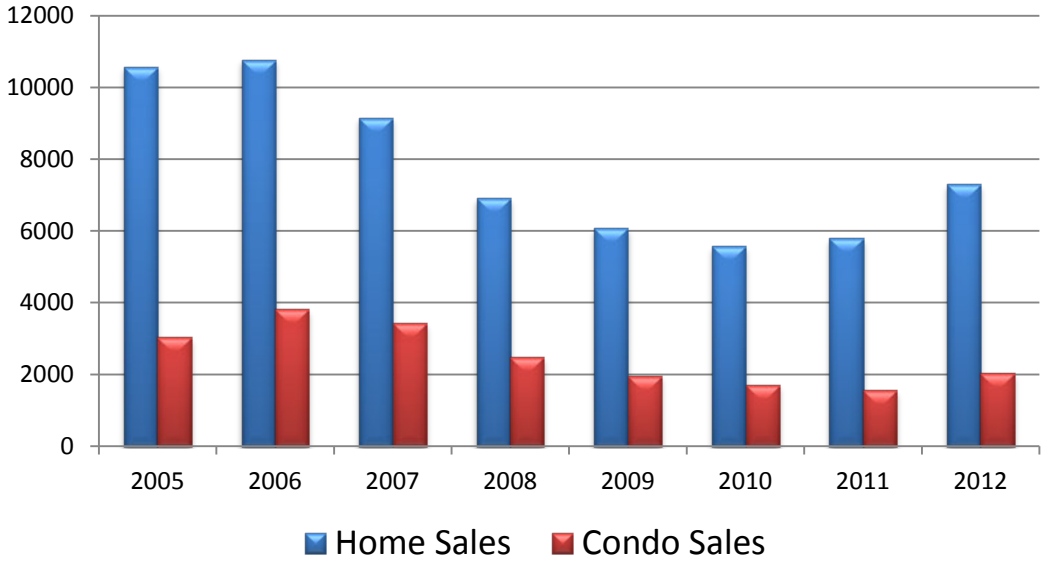
Source: THDA, *Tennessee Foreclosure Trends 2011– How many/where/patterns*, February, 2012
http://www.thda.org/index.aspx?NID=177

In 2012, Davidson County had 818 foreclosure filings in the second quarter, down from 930 in the first Quarter. THDA's *2012 Tennessee Housing Market at a Glance* reported a 13% decrease in foreclosure filings from Quarter 2 of 2011 to Quarter 2 of 2012.
http://www.thda.org/DocumentView.aspx?DID=2818

RealtyTrac reported that in October 2012 Davidson County had 212 foreclosure actions, with the highest foreclosure rates in the areas of Whites Creek (1 in 459), Old Hickory (1 in 593), and Antioch (1 in 780).
http://www.realtytrac.com/trendcenter/tn/davidson-county-trend.html

As reported by the Greater Nashville Association, Chart H-7 shows the changes in annual home sales since 2005 in Davidson County. After declining sales from 2007-2010, sales began to increase, which is another indication of a gradually recovering housing market.

Chart H-7: Annual Home and Condominium Sales
Davidson County, 2005-2012



Source: Greater Nashville Association of Realtors, http://www.gnar.org/area_home_sales

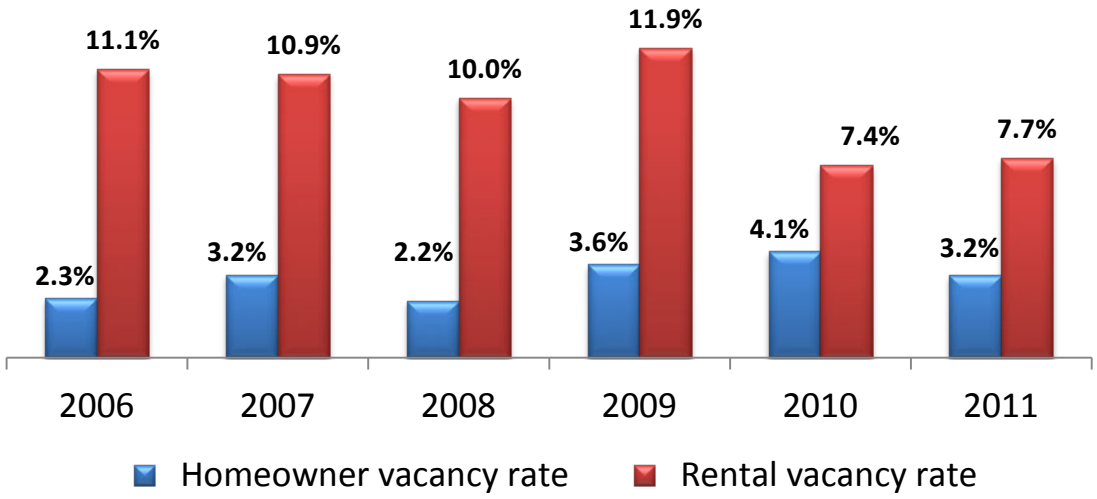
Vacancy Rates

There continues to be a lack of affordable housing in Davidson County, aggravated by the effects of the economic and housing crisis, such as restricted lending, continuing foreclosures and distressed sales, and unemployment. In the past several years, some middle-income families began searching for more affordable housing, as low-income families have been doing.

As described in a 2012 issue paper by Metro Social Services, the higher the vacancy rate, the greater the housing availability, although it does not reflect the qualitative characteristics of the available housing. Neighborhoods with high vacancy rates are often linked with negative circumstances, such as decreased property values and increased crime.
http://www.nashville.gov/sservices/docs/resources/HousingVacancies_1203.pdf

Chart H-8 shows that Davidson County homeowner vacancy rates generally increased since 2006, and rental vacancy rates decreased. The assumption is that some homeowners moved from ownership to renter. In addition, it is probable that younger people establishing households preferred renting.

Chart H-8: Vacancy Rates, Homeowners and Renters
Davidson County, 2006-2011

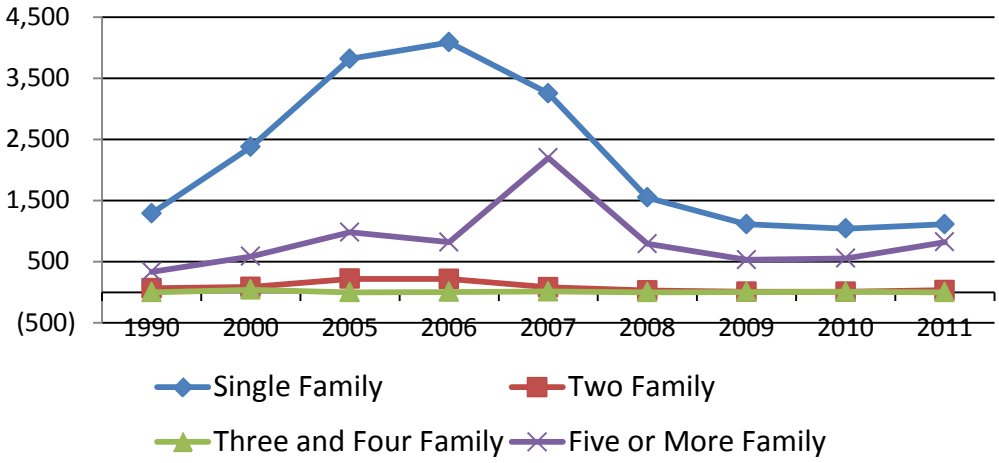


Source: 2010 American Community Survey 1-Year Estimates, Table CP04

Housing Construction, Sales and Rent

Another indication of the slowly recovering housing market is the slightly increased number of new privately-owned residential building permits for Davidson County, as shown in Chart H-9.

Chart H-9: Number of Building Permits Issued by Size of Structure
Davidson County, 1990-2011



Source: U.S. Census Bureau, Censtats Database 2011

A contributing factor in slowing the improvement in the local housing market could be that both the sales price and gross rent increased in 2011 after brief period of decline, making housing less affordable. Charts H-10 and H-11 show the sales price and rent trends in Davidson County from 2002-2011.

Charts H-10 & H-11: Home Sales Price and Gross Rent Trends
Davidson County, 2001-2011

Chart H-10: Median Home Sales Price
Davidson County, 2011

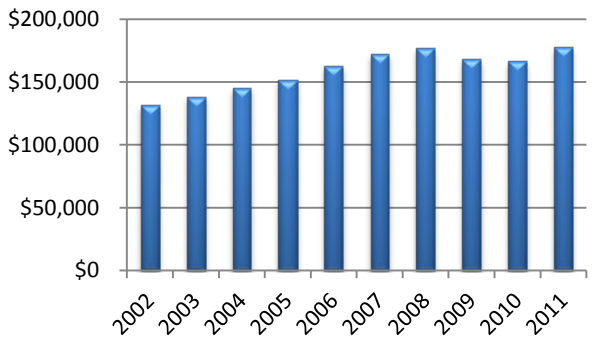
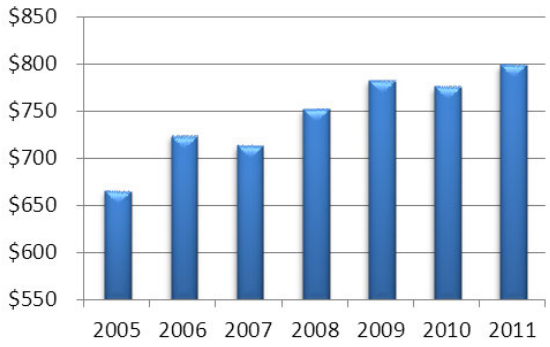


Chart H-11: Median Gross Rent
Davidson County, 2011



Sources: Tennessee Housing & Development Agency, *Tennessee Homes Sale Price and Volume Data*, and *2012 Tennessee Housing Market at a Glance*; ACS 1-Year Estimates, 2005-2010, Table B25064, Median Gross Rent for Renter-Occupied Housing Units Paying Cash Rent

Housing Affordability

In *A Comparison of 25 Years of Consumer Expenditures by Homeowners and Renters,* the U.S. Bureau of Labor Statistics reported several interesting housing-related details. From 1986-2010 overall expenditures by homeowners and renters remained about the same. However, during that time period both owners or renters spent more on housing, insurance and health care and less on transportation, food and clothing. Although homeowners spent more on housing, renters (who are likely to have lower comparable income) spent a greater percentage of their income on housing. http://www.bls.gov/opub/btn/volume-1/a-comparison-of-25-years-of-consumer-expenditures-by-homeowners-and-renters.htm

Families paying more than 30% of their income for housing are considered housing cost-burdened, and they often must make choices between paying for housing and paying for competing life necessities, such as food, clothing, transportation, and medical care. Families who spend 50% or more of their income for housing are considered severely cost-burdened. In Tennessee, housing costs are lower than those in the Southeast, which are in turn lower than the country as a whole. However, many people are spending more than 30% of their household income on housing expenses, according to the Tennessee Housing and Development Agency's *Tennessee Housing Market at a Glance 2012* and *2012 Tennessee Housing Needs Assessment.*

Periodically HUD gets custom data from the Census Bureau called CHAS data (Comprehensive Housing Affordability Strategy), to look at housing needs, especially for low-income households. CHAS data for 2005-2007 indicate that in Davidson County there were 23,540 owners and renters who earned less than or equal to 30% of the Area Median Income who were cost-burdened.

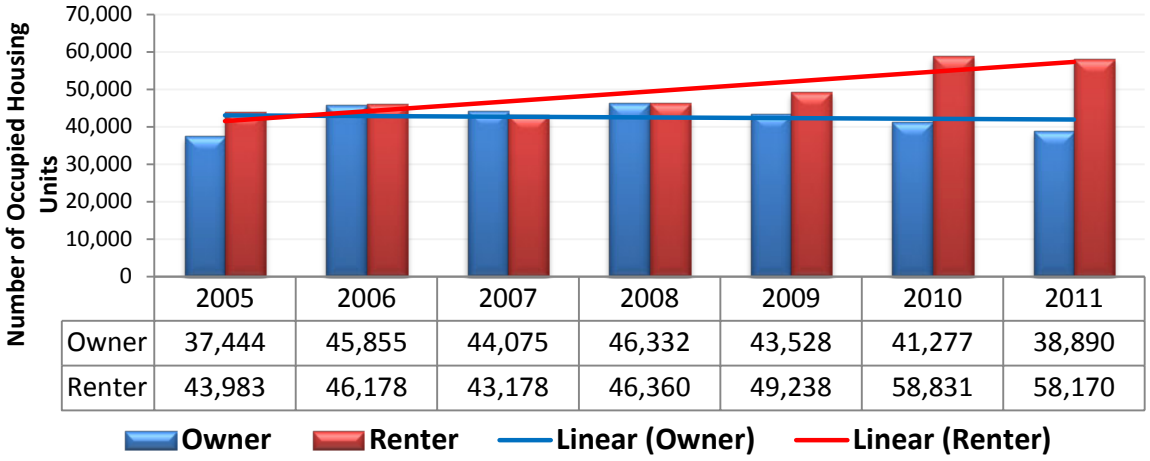
Of low-income owners, 1,820 were moderately cost-burdened (spending 30%-50% of household income on housing and related expenses). There were 5,340 low-income owners who were severely cost-burdened (spending 50% or more of household income for housing and expenses). More renters were cost-burdened in each income category. There were 2,915 moderately cost-burdened low-income renters, and 13,465 severely cost-burdened renters. Presumably, the numbers of low-income cost-burdened residents has risen since these numbers were collected.
http://www.huduser.org/portal/datasets/cp.html

A Center for Budget & Policy Priorities *Federal Assistance Fact Sheet* published in December 2012 lists various data about cost-burden in Tennessee in 2011. They report that 44% of low-income renters in Tennessee are cost-burdened at the 30% level and 70% are severely cost-burdened, paying more than 50% of their household income for housing costs. Families with children made up 31% of cost-burdened renters, and 30% of severely cost-burdened renters.
http://www.cbpp.org/files/4-13-11hous-TN.pdf

Lower home prices and favorable borrowing conditions were experienced in some areas during 2011. However, because homebuyers or renters were often employed in low-paying service sector jobs, single wage-earner households would be cost-burdened in buying or renting a median priced home. According to the 2011 American Community Survey, there have been gradual increases in median gross rent since 2007. These ranged from $714 in 2007 to $799 in 2011.

The 2011 ACS one-year estimate (tables DP04 and S25070) indicates that 35.6% of all Davidson County owners with a mortgage were paying more than 30% of household income for housing costs, and that 49.6% of all renters were paying more than 30%. Chart H-12 shows the number of Davidson County households that were cost-burdened, by tenure (owner or renter).

Chart H-12: Owner and Renter Cost Burden
Davidson County, 2005-2011



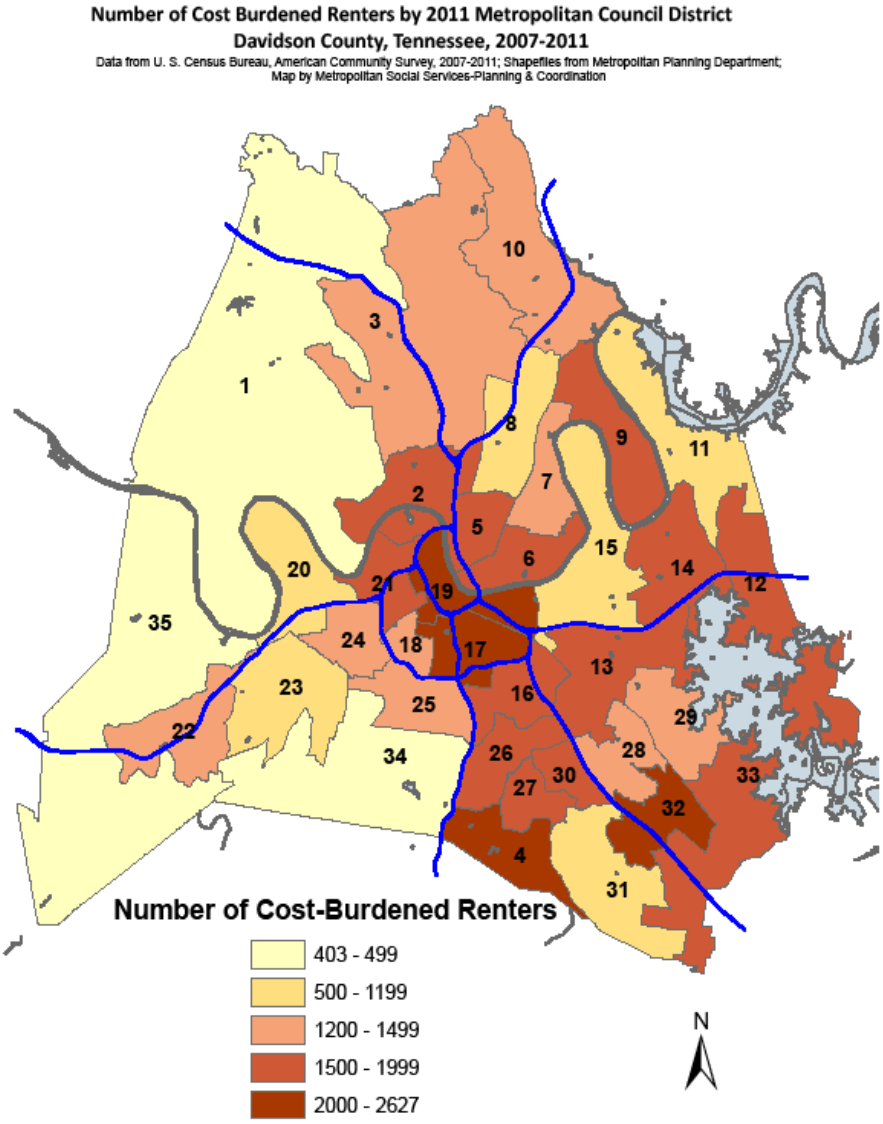
	2005	2006	2007	2008	2009	2010	2011
Owner	37,444	45,855	44,075	46,332	43,528	41,277	38,890
Renter	43,983	46,178	43,178	46,360	49,238	58,831	58,170

Source: 2011 ACS, Table B25106

Housing cost-burdens will also be experienced by older poor households in the near future, as described by the Center for Housing Policy in *Housing an Aging Population – Are We Prepared?* Property taxes, maintenance, and utility costs all tend to rise over time, but income decreases with

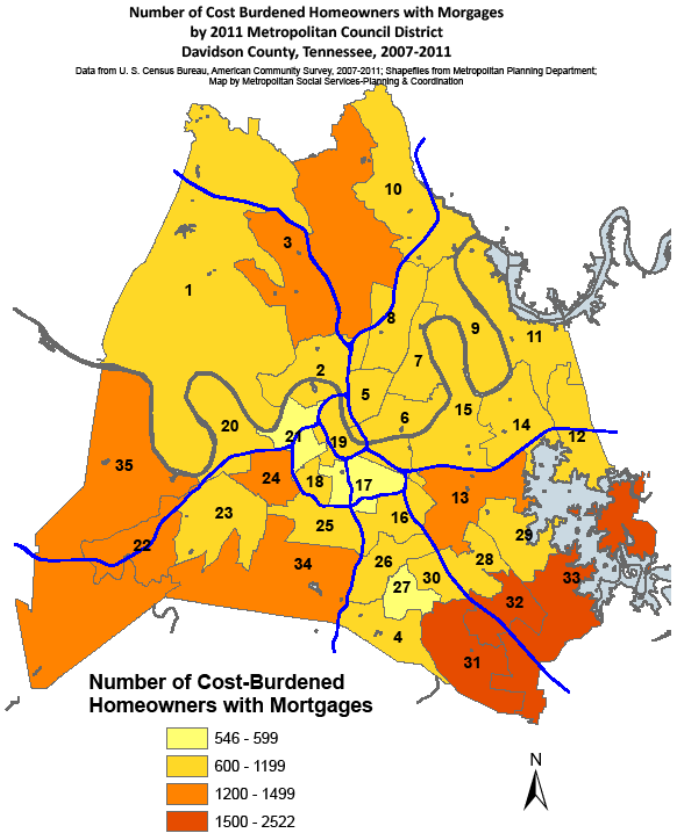
age. The recent recession has caused some elders to use retirement savings and home equity for living expenses.

One in four households age 85 and older pay at least half their income for housing, as compared with about one in five households aged 65–74 and about one in six households younger than 65. An additional source of housing costs for older people is the need to renovate/retrofit their homes to accommodate increasing mobility and access needs.
http://www.nhc.org/media/files/LosingGround_10_2012.pdf



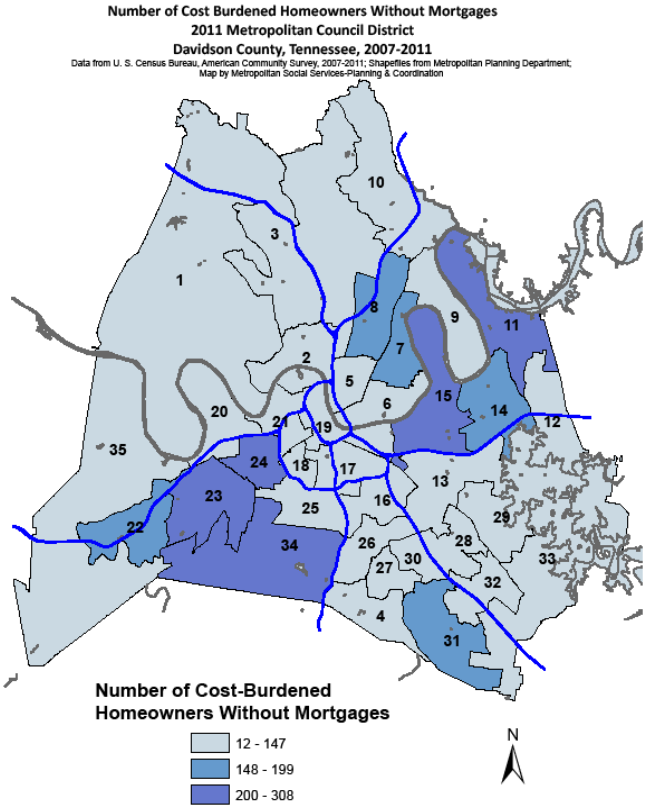
The map on the left shows the number of renters who spent more than 30% of their income on housing (cost burdened) by Metro Council District. District 34 had the fewest with 403, ranging up to 2,627 in District 19.

Source: 2002-2011 American Community Survey 5-Year Summary



The map on the left shows the number of homeowners with mortgages spending at least 30% of their income on housing. Fewest are in District 17 with 546, with the highest number in District 31 with 2,522.

Source: 2002-2011 American Community Survey 5-Year Summary



Homeowners without mortgages are far less likely to spend 30% or more of their income on housing. As reflected in the map on the right, in Metro Council District 33, there are only 12, while there are 308 in District 23.

Source: 2002-2011 American Community Survey 5-Year Summary

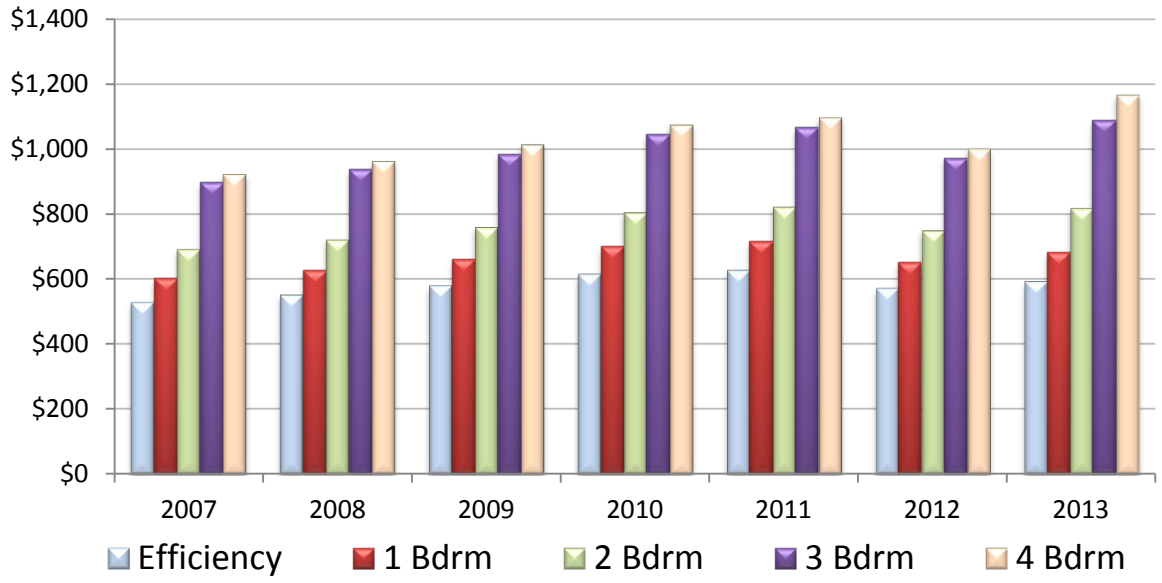
Housing Barriers

The Fair Housing Act of 1968 established rules meant to prohibit a homebuyer or renter from discrimination on the part of the home seller or property owner. Its main purpose is to make it unlawful to refuse to sell, rent to, or negotiate with any person because of that person's race, color, national origin, religion, sex, familial status or disability. It also covers a variety of housing-related actions, such as advertising, mortgage lending, homeowner's insurance and zoning.

Fair Market Rents (FMRs), determined annually by HUD, are estimates of the amount a rental units of various sizes would bring if on the open market in an area. HUD estimates FMRs for metropolitan statistical areas, including the Nashville-Davidson/Murfreesboro/Franklin MSA, and 2,045 non-metropolitan county areas. FMRs are estimates that include rent, and the utilities the renter pays (except for things like telephone, cable or satellite TV, internet service and the like). HUD FMRs may be found on the HUDUSER website http://www.huduser.org/portal/datasets/fmr.html.

HUD Fair Market Rent estimates for the Davidson County MSA are available through 2013, and have risen each year from 2007 to 2013, with the exception of 2012, as shown in Chart H-13.

Chart H-13: Fair Market Rent Trend
Davidson County MSA, 2007-2013



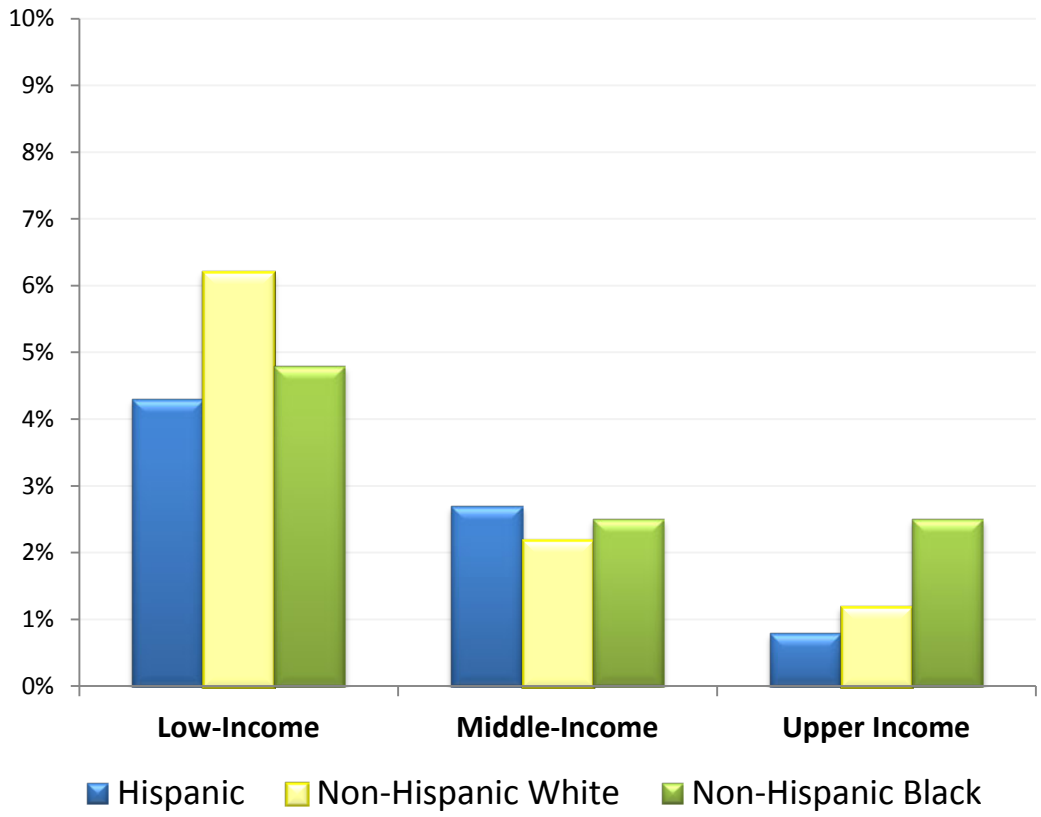
Source: HUDUSER, FMR Documentation, http://www.huduser.org/portal/datasets/fmr.html

In its 2012 report about affordable housing, the National Low-Income Housing Coalition reported in *Out of reach 2012* that in Tennessee, 1.7 full-time jobs at minimum wage are needed to rent a 2-bedroom apartment at the state Fair Market Rate of $653. For the Nashville-Davidson/Murfreesboro/Franklin MSA, the report states that two full-time jobs are needed to rent a 2-bedroom apartment at the MSA Fair Market Rent of $751.
http://nlihc.org/sites/default/files/oor/2012-OOR.pdf

Discrimination is a barrier to housing opportunity for racial and ethnic minorities, and others. The Tennessee Fair Housing Council reports that in Davidson County the number of cases opened for people that have experienced legitimate housing discrimination as defined by the Fair Housing Act has increased each year from 2009. There were 44 legitimate discrimination cases opened in calendar year 2011, and as of October 2012, the trend is that they will open more than 70 cases, about 6 cases per month.

Income, race and ethnicity are related to the proportion of high-interest loans used to purchase homes, as is the racial/ethnicity mix of the neighborhoods in which the borrowers live. Income, more than race or ethnicity, appears to have played a greater role in the issuance of high interest home loans in the Nashville MSA in 2010, as seen in Chart H-14, with low-income borrowers receiving more high-interest loans regardless of race or ethnicity.

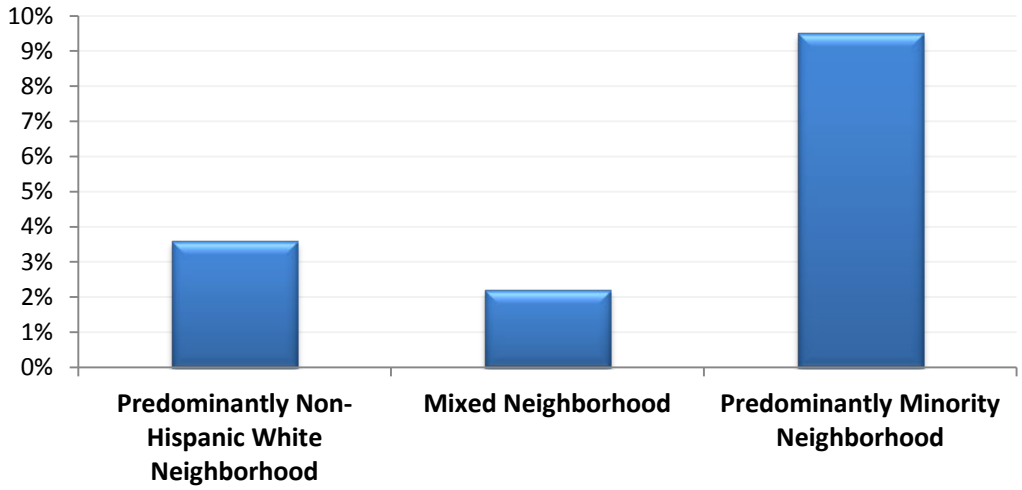
Chart H-14: Percent of High Interest Rate Loans as Share of Refinance Loans By Race/Ethnicity and Income
Davidson County MSA 2010



Source: Harvard School of Public Health, www.DiversityData.org

People living in predominately minority neighborhoods were about three times more likely to receive a high-interest home loan as those in predominately non-Hispanic white neighborhoods as shown in Chart H-15.

Chart H-15: Percent of High Interest Rate Loans as Share of Refinance Loans by Neighborhood
Davidson County MSA 2010



Source: Harvard School of Public Health, www.DiversityData.org

Housing and Transportation

There is a trade-off between housing and transportation costs in that lower housing costs are often in transportation-poor areas, and housing in transportation-rich areas often costs more. The Center for Housing Policy (CHP) and the Center for Neighborhood Technology (CNT) have studied the combined housing + transportation cost burden of working families and concluded:

- Housing and transportation costs have been rising faster than household income.
- Moderate-income households (50-100% of area median income) pay almost 60% of their income for housing and transportation.
- The worst cases of combined cost burden are in areas that have high housing/transportation costs and low incomes.

http://www.nhc.org/media/files/LosingGround_10_2012.pdf

The CNT has developed a Housing+Transportation (H+T)® Affordability Index that can be used to evaluate the H+T costs of over 900 regions in the U. S. Using the Index, they conclude that H+T affordability has declined since 2000, and that 72% of U. S. communities are unaffordable to typical families when housing and transportation costs are combined. The CNT defines a regional typical household as one with "…a household income that is the median income for the region, the average household size for the region, and the average commuters per household for the region." Using the

Index, the CNT calculates that the Nashville MSA H+T cost for a regional typical household is 52.8% of their income.
http://www.cnt.org/repository/2012-Fact-Sheet-Rankings.pdf

Neighborhoods

Research about the effects on neighborhood environments on the well-being of residents is mixed. Although there have been studies about a variety of neighborhood characteristics, like poverty, school achievement, crime, household income, *etc.*, neighborhood characteristics are difficult to measure with confidence. However, it appears that poor and deteriorating neighborhood physical environments have negative effects on most characteristics. It also appears that subjective well-being is affected more by neighborhood economic disadvantage than by racial segregation. Racial segregation has been declining since 1970, but income segregation has been increasing.

Measuring Neighborhood Quality With Survey Data: A Bayesian Approach, HUD Cityscape journal, 2010,
http://www.huduser.org/portal/periodicals/cityscpe/vol12num3/ch7.pdf

In a review of literature about how living in a mixed-income community affects low-income families, researchers from The Urban Institute summarized findings of a variety of research efforts. They reported that moving low-income families into neighborhoods with a range of household incomes (income-diverse or mixed-income) appeared to have several benefits to the low-income families. Although most studies have some kind of threat to validity, which causes the authors to be cautious about conclusions, there are tantalizing similarities among positive findings across the studies reviewed. Some of these positive aspects of moving from poverty-concentrated to mixed-income neighborhoods include the following:

- Resident reports that housing quality and the location of mixed-income developments are good, and that there are benefits in terms of mental health, educational opportunities, neighborhood services and amenities, reduced stress from increased safety, increased self-esteem, and increased motivation.
- Better job outcomes, such as more job contacts, more racially diverse job networks, and higher levels of occupational prestige. Using vouchers to rent housing renting is correlated with reported higher rates of employment than living in site-based public housing.
- Family reports of fewer mental or emotional health problems and improved physical health. Children reported feeling less sad, arguing less and disobeying their parents less often. They reported working harder in more challenging schools and did not experience a drop in grades relative to non-movers.
- Some small positive changes have been reported in people's understanding of others' cultures and perceived prejudices. One study found that some residents reported benefits of mixed-income developments due to learning about residents from different socioeconomic backgrounds.

http://www.urban.org/publications/412292.html

In May 2012, The Urban Institute published the results of a review of literature titled *The Impact of Housing on School Outcomes: What the Research Says*. The report details the findings of the research reviewed, and discusses the methodological limitations of the studies. However, despite the cited methodological issues, their conclusion is that adequate housing is essential for meeting children's basic needs and that it can help improve educational outcomes.

The Impact of Housing on School Outcomes also concluded that the research shows putting more resources into housing that improves educational outcomes may result in improved employment outcomes, of benefit to the community as a whole. They recommend more research to address some of the research shortcomings.
http://www.urban.org/UploadedPDF/412554-Housing-as-a-Platform-for-Improving-Education-Outcomes-among-Low-Income-Children.pdf

Recent research suggests that families that are behind on rent or mortgage payments are more likely to experience a negative effect on their physical, mental and emotional health, mental, as well as development and cognitive development. In January 2011, Children's HealthWatch described research in *Behind Closed Doors: The Hidden Health Impacts of Being Behind on Rent* that examined differences in the health and well-being of mothers and young children in families that are behind on rent or mortgage payments, and those in stable housing and in homeless shelters.

The research described *in Behind Closed Doors* shows that families that have been overdue on their rent or mortgage are more likely to be in poor health and experience depression, and their children are more likely to have developmental delays, similar to mothers and children in homeless shelters. Specifically, the children in families overdue on housing payments are more likely to have social, emotional, motor or cognitive development delays, and to be below average in length or height. The report states strongly that being behind on rent or mortgage puts families at risk of poor mother and child health, as well as at risk for homelessness.
http://www.childrenshealthwatch.org/upload/resource/behindcloseddoors_report_jan11.pdf

Child Poverty and Its Lasting Consequence (September 2012) from the Urban Institute explains that children in families that move for negative reasons (eviction, foreclosure, divorce, etc.) are less likely to graduate from high school by age 20. Children whose families move for positive or neutral reasons are not negatively affected in this way. Negative moves indicate periods of instability and economic hardship that may impair academic achievement, particularly if the move requires a change in schools.
http://www.urban.org/publications/412659.html

According to THDA's *Tennessee Housing Needs Assessment*, in 2011 38,020 (34.6%) of Davidson County's low-income households had severe housing problems as defined by HUD. Davidson County had 12.5% of the state's low-income households with severe housing problems. The THDA 2012 Needs Assessment reported that 32.8% (14,185) of Davidson County low-income owner households had severe housing problems, as did 23,835 (35.8%) of low-income renter households.
http://www.thda.org/DocumentView.aspx?DID=2819

During the housing crisis, low-income neighborhoods had a greater rate of high-interest loans contributing to neighborhood foreclosures. Foreclosed houses affect entire neighborhoods by

reducing the property values, which can lead to increasing deterioration and crime. Neighborhoods with dilapidated housing also tend to have underperforming schools, more unemployment, and fewer grocery stores, banks, and other amenities. Research continues to show that children growing up in disadvantaged neighborhoods do more poorly in school, are less healthy, and are more aggressive and prone to criminal behavior.

The Brookings Institution's *Housing Costs, Zoning, and Access to High-scoring Schools* (April 2012) ranked metropolitan areas using the 2005-2009 ACS, data on school populations, state standardized test scores for 84,077 schools in 2010 and 2011, and other data. Their 2012 report indicates that the Nashville-Davidson/Murfreesboro/Franklin MSA scored poorly in access to quality education. They ranked the Nashville MSA 57th worst in economic segregation out of 100 areas. Housing near high-scoring elementary schools was 2.3 times as expensive as housing near poorly-performing schools.
http://www.brookings.edu/research/papers/2012/04/19-school-inequality-rothwell/profiles

According to *Housing an Aging Population – Are We Prepared?* by the Center for Housing Policy, the lack of public Transportation and alternatives is a significant problem in some neighborhoods. Public transportation often is not available when needed, for example to get a worker to and from a third-shift job, or to get a single mother to and from both daycare and work in a timely manner. Older adults also need transportation alternatives. It is predicted that 86% of older adults age 65-79 in Davidson County in 2015 will have poor transportation access.
http://www.nhc.org/media/files/AgingReport2012.pdf

Homelessness

HUD's new definition of homeless is in the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH), which was signed into law in May 2009. In a January 18, 2012 Federal Policy Brief, there were changes in the HUD Definition of "homeless." The groups of people who qualify for assistance from programs using HUD funds have been expanded to the four general categories below.

1. People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution.
2. People who are losing their primary nighttime residence within 14 days and lack resources or support networks to remain in housing.
3. A new category is Families with children or unaccompanied youth who are unstably housed and likely to continue in that state.
4. People who are fleeing or attempting to flee domestic violence.

In its *State of Homelessness in America 2012*, the National Alliance to End Homelessness reported that in 2011 the national rate of homelessness was 21 homeless people per 10,000 people in the general population. The rate for veterans was 31 homeless veterans per 10,000 veterans in the general population.
http://www.endhomelessness.org/library/entry/the-state-of-homelessness-in-america-2012

For its *2010 Annual Homeless Assessment Report to Congress*, HUD reported that the Nashville MSA had 22.6% of the total statewide homeless count.
http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf

In the 2012 *Hunger and Homelessness Survey* of 25 cities for the U. S. Conference of Mayors, Nashville service providers' responses indicated that lack of affordable housing was the greatest cause of homelessness among both individuals and families with children. Other housing issues were also cited as contributing to homelessness in Nashville: poverty, unemployment, eviction, and lack of needed services.

In the survey, Nashville reported a 23% increase in the number of unaccompanied adults needing emergency shelter who did not receive it. Also reported was a 20% increase in homeless families. Nashville responses indicated that the city expected to have a moderate increase in the number of homeless individuals and families, but a moderate decrease in resources to provide emergency housing for them.

When surveyed about the main actions needed to reduce homelessness, twenty-two (88%) of the surveyed cities indicated provision of more mainstream assisted housing (such as housing vouchers), and 72% said more permanent supportive housing for people with disabilities was needed.
http://www.usmayors.org/pressreleases/uploads/2012/1219-report-HH.pdf

In January 2012 the National Alliance to End Homelessness reported that the Nashville MSA homeless rate was 14 homeless people per 10,000 in the general population, and it ranked 40th among the top 100 U. S. MSAs. For comparison, the Charlotte-Gastonia-Concord NC-SC MSA had 18 homeless per 10,000 people and was ranked 32nd and the Indianapolis-Carmel IN MSA had 9 homeless per 10,000 with a rank of 52 among the top 100 MSAs.
http://www.endhomelessness.org/library/entry/the-state-of-homelessness-in-america-2012

Additional information about the effects of homelessness on a variety child development issues is provided in this report in the Health and Human Development chapter.

At the Davidson County level, the Metropolitan Homelessness Commission (part of Metropolitan Social Services - MSS) brings together advocates, nonprofit organizations, businesses, government agencies and others to work toward ending homelessness in Nashville. As of November 2012, The Metro Homelessness Commission/Key Alliance reported on its web site that Nashville has about 4,000 homeless individuals and families including children.

In 2011, there were just over 2,000 homeless children identified by the Metro Nashville Public Schools. However, it was noted that often parents do not report their homeless condition to the school for fear of losing their children. Staff members at the schools indicated that there were middle and high school students who are too embarrassed to report that they are homeless, or have no fixed address because they live temporarily with friends (couch surfing). The 2011 Davidson County Point-in-Time Count

taken on a single night in February reported 2,245 homeless individuals (360 living outdoors and 1,885 in shelters.

HUD changed the requirement for Point-In-Time counts of homeless persons to every two years. As a result, no count was conducted in Davidson County for 2012. Data for annual counts for 2004-2011 are in the 2011 Community Needs Evaluation.

Public Housing

The Metropolitan Development and Housing Agency (MDHA) is Davidson County's municipal housing authority that serves as the conduit for U. S. Housing and Urban Development (HUD) funding. The mission of MDHA is to "…create affordable housing opportunities for Nashvillians, nurture our neighborhoods, and build a greater downtown."

MDHA operates over 5,000 units in public housing properties. There are 13 family housing properties, with various sizes of apartments, from efficiencies to 5-bedroom units, scattered in zip codes 37203, 37204, 37206, 37207, 37208, 37209, and 37210. It also operates multi-unit facilities for low-income, elderly and disabled residents. In addition to its properties, MDHA manages Rental Assistance Voucher Programs, which provide rent subsidies to help families find housing in the private market. In voucher programs, the family pays 30%-40% of adjusted income for monthly rent and utilities (minimum payment is $50) and MDHA pays the difference between that and the market rate for the housing.

Other MDHA residential-related programs include the Family Unification Program for families who might lose custody of their children due to unsuitable housing, and the Family Self-Sufficiency program that links residents with needed community services to increase their independence. MDHA operates two programs directed to neighborhoods: The Neighborhood Infrastructure Program and the Neighborhood Enhancement Program.

The infrastructure program funds improvements in low-income census tracts, such as sidewalks, street lighting, etc. The Enhancement program funds projects to enhance the appeal and livability of neighborhoods, such as playgrounds, bus shelters and community gardens. MDHA has community gardens, operated by resident associations, at four public housing properties. There are also programs that provide financial assistance to agencies to provide community-based services to enhance the quality of life of low-income residents and homeless citizens.

The Tennessee Housing Development Agency's (THDA) provides programs to assist people, as well as analyses of Tennessee's housing market and needs, by county.
http://tn-tennesseehda.civicplus.com/archives/42/cover_RN352.pdf
http://www.thda.org/DocumentView.aspx?DID=2819

Tennessee Housing Market at a Glance:
http://tn-tennesseehda.civicplus.com/archives/43/TN%20Housing%20Market%20at%20a%20Glan_RN379.pdf

Long-Term Services and Supports

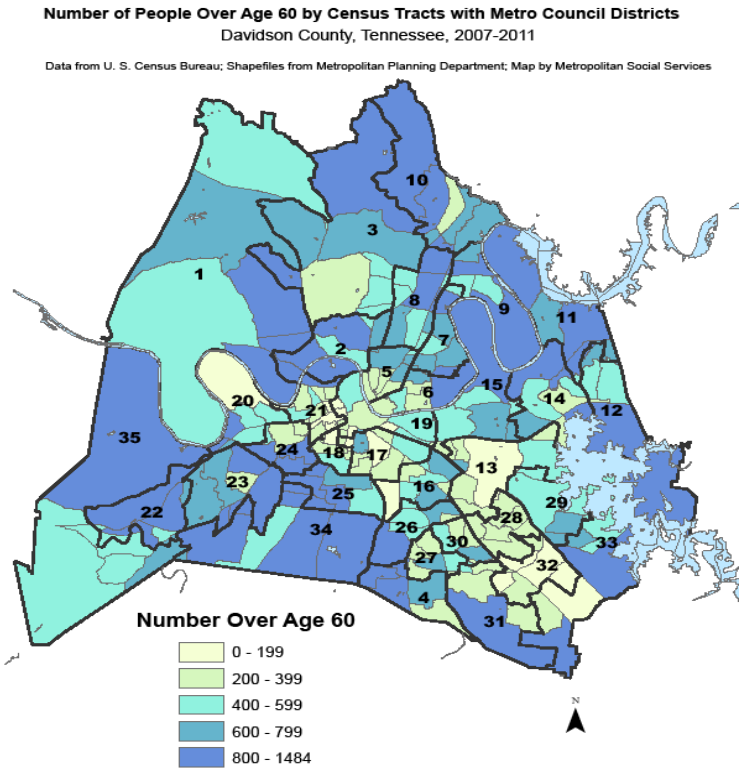
Key Findings

- **There is an increasing need for Long-Term Services and Supports (LTSS) for seniors and adults with disabilities, due to the increasing number of seniors and the higher incidence of disabilities age increases.**
- **The number of seniors age 60 and above is projected to substantially increase nationwide, in Tennessee and in Davidson County by 2030.**
- **People who are age 65 or older are more than 5 times as likely to have an ambulatory difficulty than those who are younger.**
- **LTSS is less costly than nursing home care and preferred by consumers.**
- **Persons with a disability are more likely to have incomes below the federal poverty level.**
- **TennCare CHOICES enrollment has nearly tripled in the past two years.**

Long-term Services and Supports (LTSS) are a continuum of supportive services needed by people who have limitations in their capacity for self-care because of a physical, cognitive, or mental disability or condition. LTSS can be both institutional (provided in a skilled nursing facility) or non-institutional (provided in a home or community setting). Non-Institutional LTSS are often referred to as home and community based services.

According to an AARP Public Policy Institute Report, more than 11 million adults need long-term support services. Unpaid family caregivers coordinate and provide many of these services for persons who otherwise may need costly institutional care. The AARP Report indicates that Medicaid can provide the less expensive LTSS to three people for every one person served in a skilled nursing facility. The federal government and individual states are developing strategies to increase funding for Long-Term Support Services while reducing funds to institutional care in response to consumers indicating a desire to remain in their homes.
http://www.aarp.org/content/dam/aarp/about_aarp/aarp_policies/2011_04/pdf/Chapter8.pdf

Seniors are not evenly distributed across Davidson County, with a higher number outside the central city area. The U. S. Census Bureau's 2007-2011 American Community Survey 5-Year Summary reports that there were 92,824 people over age 60 in Davidson County. The map below shows the number of people over 60 by Census Tract, with Metropolitan Council Districts also shown. While 13 of Davidson County's 161 Census Tracts have fewer than 200 people over age 60, 21 others have more than 1,000 people over 60 per Census Tract.



Eligibility

Eligibility for Long-Term Services and Support varies from state to state and by funding source, (generally persons who qualify for non-institutional LTSS need help with activities for daily living (ADLs) or independent activities for daily living (IADL+s) who otherwise may require institutional care. Medicaid provides most funding for LTSS, and eligibility is based upon age, income, assets and mental or physical disabilities. For people who do not meet the eligibility requirements, private pay services are available. However, the costs may be prohibitive for those who do not have significant assets or long-term care insurance.

Types of Long-Term Services and Support (Non-Institutional)

There are many types of LTSS for persons desiring to remain in their homes and communities. Support services include an array of services, such as Homemaker Services, Personal Care Services, Case Management, Home Delivered Meals, Congregate Meals, Adult Day Care, Chore Services, Home Health Care, Nursing Services, Respite Care for Caregivers, Grocery Shopping, Laundry Services, Personal Emergency Response Systems, Counseling, Nutrition Education, Companionship Care, Medication Dispensing Systems, Assisted Care Living Facility Services, In-home Nursing Care, Transportation, Private Duty Nursing Services, Program for All-inclusive Care for the Elderly (PACE), Skilled Rehabilitative Services and others.

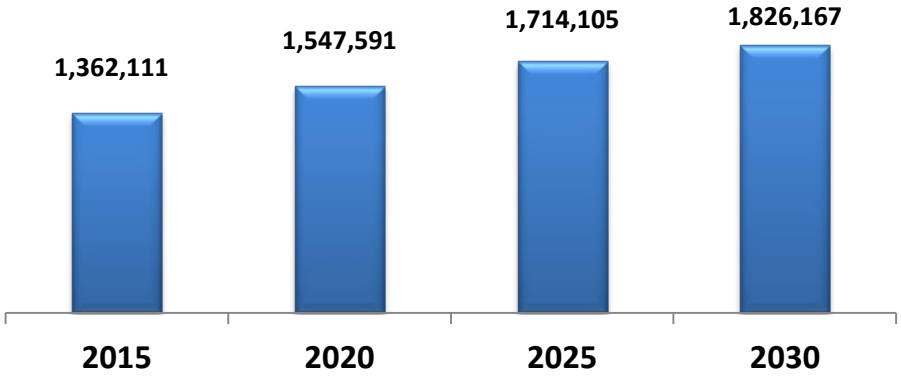
http://www.medicare.gov/longtermcare/static/home.asp
http://www.tn.gov/tenncare/long_covered.shtml
http://www.tn.gov/comaging/living.html

Increasing Need for Long-Term Services and Support

The likelihood that people will need LTSS increases as they age. According to the U.S. Census Bureau projections, the number of persons age 60 and above is expected to increase from 45.8 million in 2000 to 92.2 million by 2030, and there would be more than 112 million by 2050. Chart LTSS-1 reflects how Tennessee's population of persons age 60 and above is expected to climb by over 464,000 between 2015 and 2030. Many states and municipalities are unprepared for the aging population and the need for Long-Term Supports and Services.

Chart LTSS-1: Projected Population for Persons Age 60 and Above

Tennessee, 2015, 2020, 2025, 2030

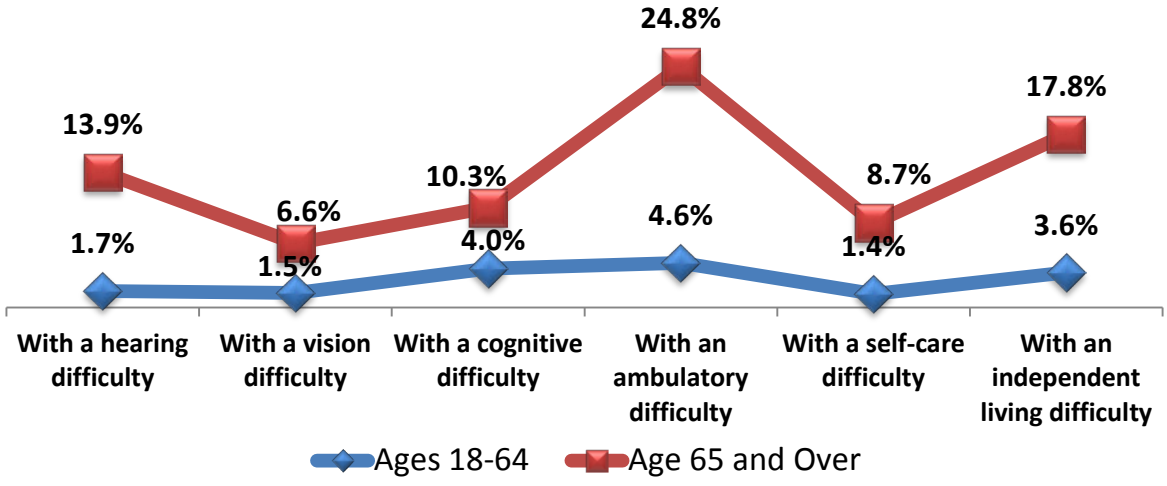


Source: Administration on Aging, *State Projections for populations age 60 and over Five Year Age Groups*

Chart LTSS-2 shows the percentage of people with various types of disabilities. According to the 2011 American Community Survey, those who are age 65 or older are much more likely to have all types of disabilities than those who are younger. The difference is particularly pronounced in ambulatory difficulties, independent living difficulties and hearing difficulties.

Chart LTSS-2: Types of Disabilities by Age Category

Davidson County, 2011

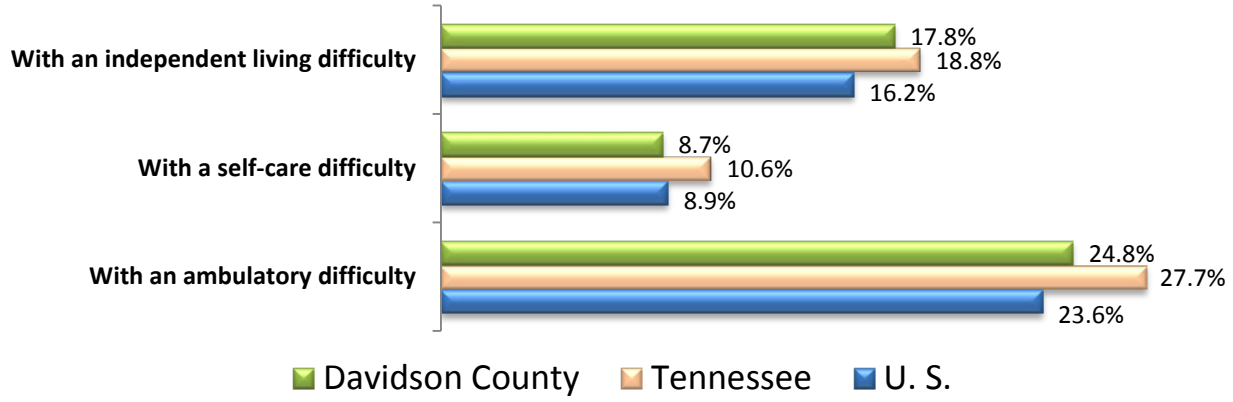


Source: 2011 American Community Survey

Chart LTSS-3 shows that in 2011, the percentage of people with independent living, self-care and ambulatory difficulties was higher for Tennessee than for the U. S. and Davidson County. Davidson County's percentages for independent living and ambulatory difficulties were higher than the U. S., but slightly lower for self-care difficulties.

Chart LTSS-3: Percent with Selected Disability

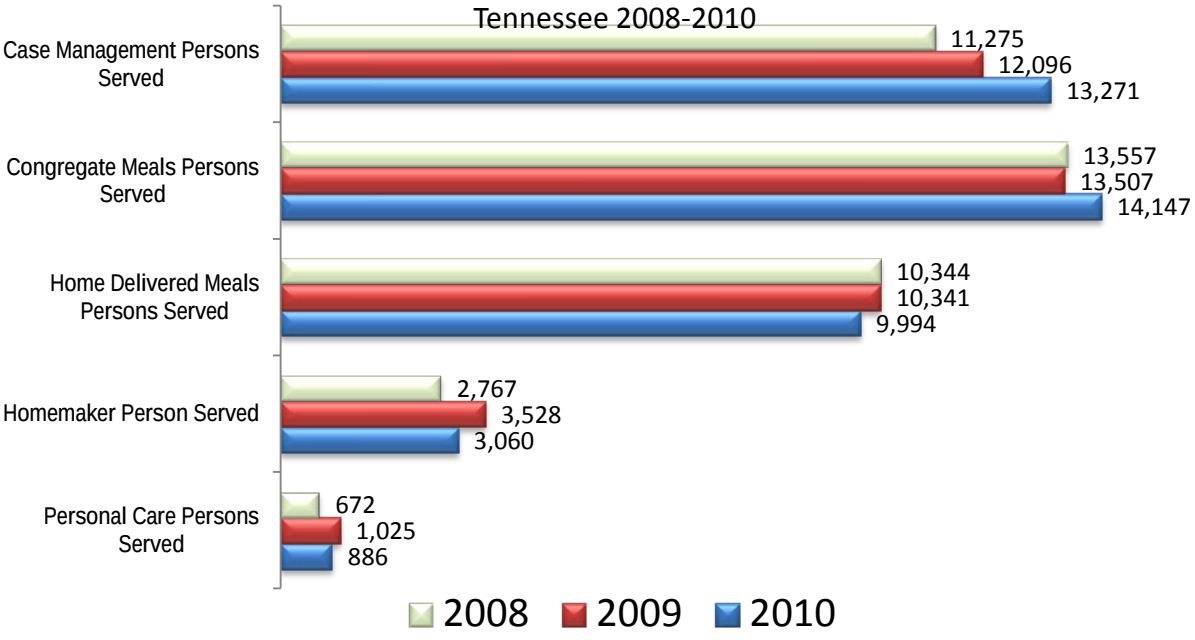
U. S., Tennessee, Davidson County, 2011



Source: 2011 American Community Survey

Homemaker services, personal care, home delivered meals, congregate meals, and case management are the more frequently used LTSS non-institutional services provided to consumers using Older American Act funds. Chart LTSS-4, shows the number of persons served in Tennessee for these specific LTSS types.

Chart LTSS-4: Number of People Served by Selected Types of LTSS



Source: *FY 2008-2010 Profile of State Older American Act Programs: Tennessee*
www.aoa.gov/aoaroot/program_results/SPR/2010/profiles/tn.xls

In the *Profile of Older Americans: 2010*, the U. S. Administration on Aging analyzed 2009 data and found that a relatively small percentage (4.1%) of people over 65 lived in institutional settings such as nursing homes. The percentage increases for older age categories, ranging from .9% for people 65-74 up to 14.3% for those over age 85. It reported that 93% of non-institutionalized persons over 65 were covered by Medicare, and about 58% had some type of private health coverage.
http://www.aoa.gov/aoaroot/aging_statistics/Profile/2010/docs/2010profile.pdf

Cost Comparison of Non-Institutional LTSS and Nursing Home Care

LTSS such as homemaker, personal care and adult day care services can cost less than nursing home care. Depending on the number and intensity of LTSS needed to help people remain in the home, there can be cost savings, as well as the desirability of home care by most individuals and families.

Medicaid and Long-Term Care Services and Supports by the Kaiser Commission on Medicaid Facts (June 2012) reported that the cost of nursing home care averages $74,800 per year and assisted living care averages $49,500 per year. Home health services cost an average of $21 per hour or unit of service, although there is no standard number of hours identified that would allow people to remain in their homes.
http://www.kff.org/medicaid/upload/2186-09.pdf

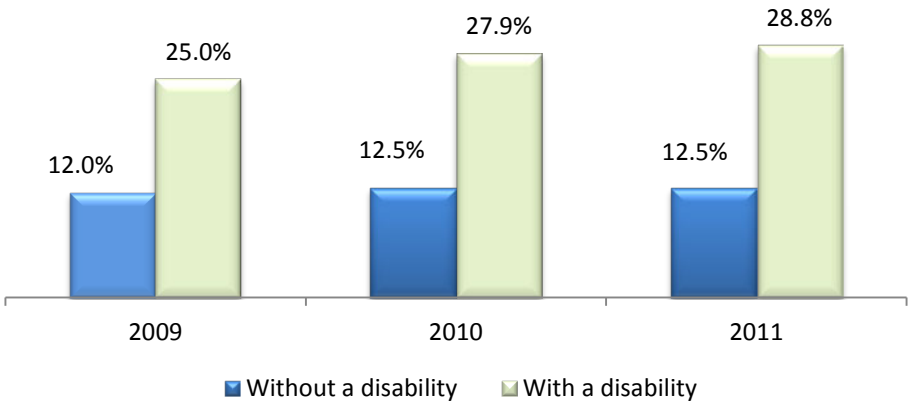
According to a report by the Center for Health Care Strategies in May 2010, about 2/3 of Americans older than 65 will eventually need some kind of long-term care. *Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options* also explains that Medicaid will pay for about 40% of these costs because few have either adequate assets or long-term care insurance.
http://www.chcs.org/usr_doc/LTSS_Policy_Brief_.pdf

Disability Status, Poverty and the Need for Long-Term Supports and Services

The need for LTSS is greater for people who have a disability. *Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options* explained that of the 10 million Americans who need long-term supports and services, 42% are under age 65. The people under age 65 include those with disabilities.

Persons age 18-64 with a disability are more likely to have incomes below the poverty line. If employed, they tend to earn less, and have lower annual median incomes than persons without a disability. As indicated in Chart LTSS-5, between 2009 and 2011, nationally the poverty rate was about twice as high for those with a disability.

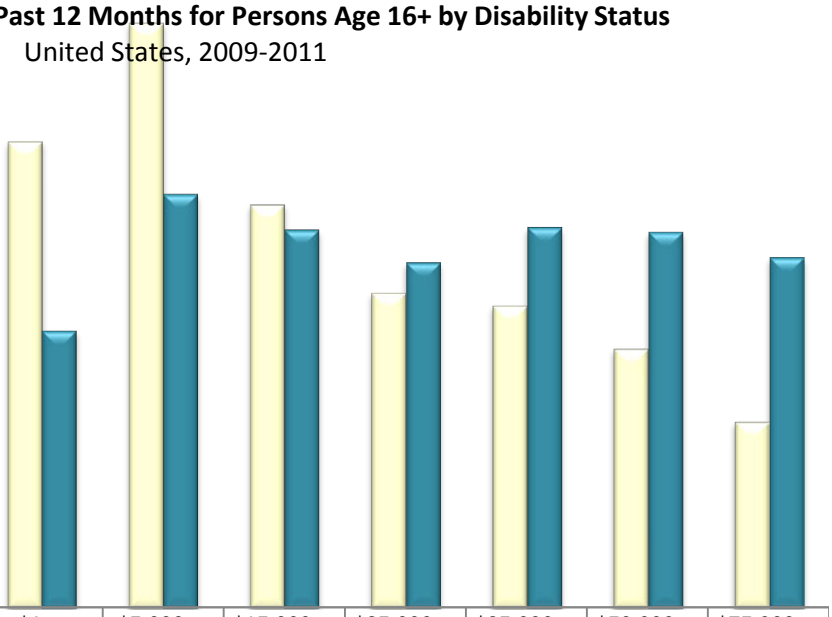
Chart LTSS-5: Percent of Poverty For Ages 18-64 Years Old By Disability Status
U.S. 2009-2011



Source: American Community Survey 2009, 2010, 2011

As shown in Chart LTSS-6, 57.7% of persons with a disability earned below $24,999 over the past twelve months as compared to 42.4% of persons without a disability earning similar amounts.

Chart LTSS-6: Earnings in Past 12 Months for Persons Age 16+ by Disability Status
United States, 2009-2011

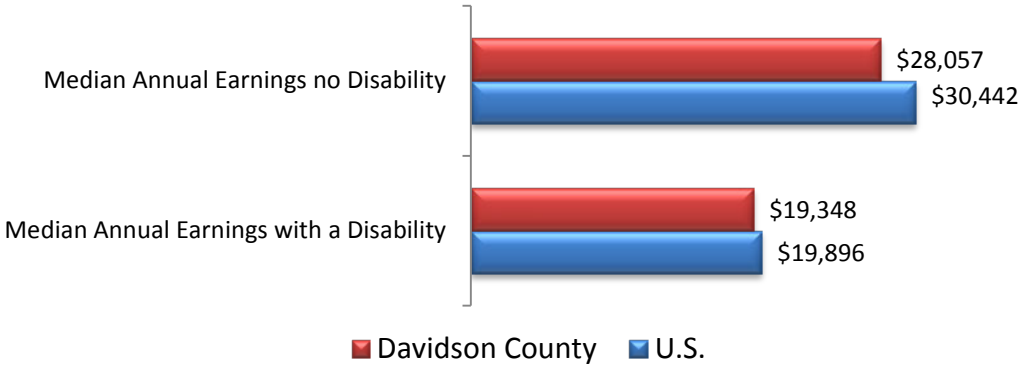


	$1 to $4,999	$5,000 to $14,999	$15,000 to $24,999	$25,000 to $34,999	$35,000 to $49,999	$50,000 to $74,999	$75,000 or more
Percent of Persons with a Disability Past 12 Months Earnings	18.5%	23.2%	16.0%	12.5%	12.0%	10.3%	7.4%
Percent of Persons without a Disability Past 12 Months Earnings	11.0%	16.4%	15.0%	13.7%	15.1%	14.9%	13.9%

Source: 2009-2011 American Community Survey 3-Year Estimates, Selected Economic Characteristics for the Civilian Non-institutionalized Population by Disability Status

Persons with disabilities have lower median annual earnings than those who do not have disabilities in the U.S. and in Davidson County, as shown in Chart LTSS-7.

Chart LTSS-7: Median Annual Earnings by Disability Status
U.S., Davidson County 2009-2011



Source: 2009-2011 American Community Survey 3-Year Estimates, Selected Economic Characteristics for the Civilian Non-Institutionalized Population by Disability Status

As shown in Chart HHD-4 in a previous section, according to the 2011 American Community Survey, people over age 65 are significantly more likely to have hearing, vision, cognitive, ambulatory, self-care and independent living difficulties than any other age category. For example, ambulatory difficulty is experienced by only 4.5% of those between 18 and 64, which increases to 24.8% for those over age 65. Hearing difficulty is experienced by 1.7% of those aged 18-64 and by 13.9% of those over 65.

According to a February 2011 report from the U. S. Government Accountability Office, as seniors age, the need will increase for transportation services due to factors such as an inability to drive and limited access to a vehicle. *Older Americans Act –More Should Be Done to Measure the Extent of Unmet Need for Services* describes the unmet need for seniors who want to be transported to multiple destinations, cultural events and trips to non-urban areas. However, in Tennessee, transportation services funded by the Older Americans Act are generally limited to medical appointments and trips to congregate meal sites. The report noted that it is likely that many older adults needed meals and home care services who did not receive services, and it indicates that more should be done to measure the extent of unmet needs for services.
http://www.gao.gov/assets/320/316099.pdf

In March 2010, the American Public Transportation Association released *Funding the Public Transportation Needs of an Aging Population* that described the need to expand mobility options for older persons. It noted that the rapidly aging population will increase the need for expanded and enhanced public transportation systems. It noted the importance of enhancements to fixed-route and planning that considers the needs of older people in stop placement, along with the need for coordination with other organizations and transportation providers. Other needed actions identified included developing methods to help older people take advantage of existing services (clear

information, outreach and training), and expansion of supplemental services (ADA paratransit, non-ADA demand-response services, taxi subsidy programs and volunteer driver programs.
http://www.apta.com/resources/reportsandpublications/Documents/TCRP_J11_Funding_Transit_Needs_of_Aging_Population.pdf

LTSS Funding Sources

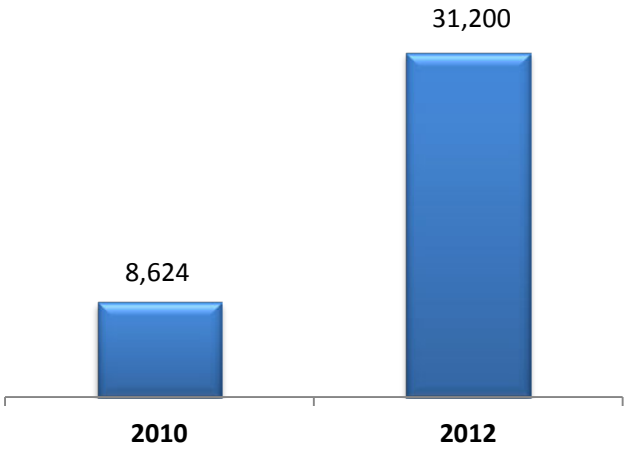
Funding for Long-Term Support Services is primarily through Medicaid. Additional funding sources include the State Options Program, Older Americans Act (OAA), Medicare and commercial long-term care insurance. Federal TennCare funds support services to special populations through various state agencies, including the Department of Children's Services, the Department of Health, the Department of Human Services, the Department of Intellectual and Developmental Disabilities, and the Department of Mental Health.

Medicaid provides medical and LTSS for persons who meet eligibility criteria based on financial and level of medical care. Financial eligibility is based on individual, family or household income and assets. Medical criteria include people who are blind or persons with a disability as defined by the Social Security Administration. Medicaid funding for LTSS has age, income and disability eligibility requirements. The eligibility guidelines for LTSS vary across states, depending upon their specific funding sources.
http://aspe.hhs.gov/daltcp/reports/primer.htm

TennCare Choices

TennCare Choices was implemented in 2010 to provide long-term supportive services to eligible individuals who preferred to and were medically able to remain in their homes. TennCare Choices was designed to increase funding for LTSS to serve more people. As indicated in Chart LTSS-8 program enrollment has dramatically increased since it began in 2010. According to figures from the Bureau of TennCare, enrollment for the fiscal year ending June 30, 2012 is now over 31,000 persons.

Chart LTSS-8: TennCare Choices Enrollment
Tennessee 2010-2012



Source: TennCare Choices

Options for Community Living

The Options for Community Living Program (Options) provides a range of LTSS to assist eligible persons to remain at home and in their community. The Options program is administered by the Tennessee Commission on Aging and Disability through the Area Agency on Aging and Disability (AAAD) and is funded by state appropriations. Eligibility for Options is based upon an in-home assessment of the individual's functional abilities.

The Options Program has no specific income eligibility requirement but uses a sliding scale fee based on income to support the program. There is usually a waiting list for Options services. According to the Greater Nashville Regional Council in 2012, a typical wait time for consumers to receive Options services is two to three years, with up to 1,200 to 1,500 on the waiting list.
http://www.tn.gov/comaging/living.html

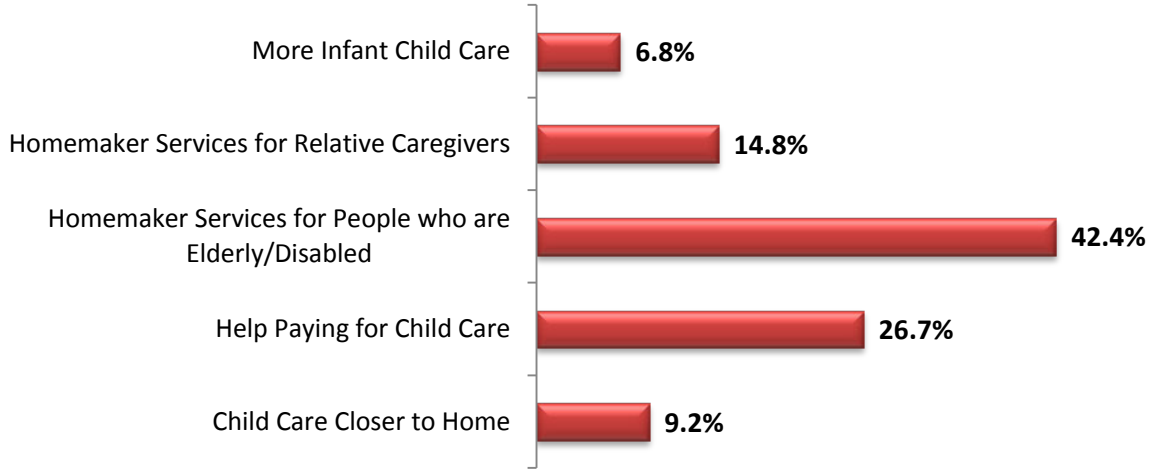
Older Americans Act – Title III

The Older Americans Act was first passed by Congress in 1965 to address the social service needs for older persons and remains a major source for social and nutrition services. Older American Act (OAA) eligibility is limited to persons aged 60 and above. Many LTSS are funded through the OAA, such as congregate meals, home delivered meals, homemaker services, personal care, legal assistance, senior centers and health promotion activities.
http://www.aoa.gov/AoA_programs/OAA/index.aspx

Grassroots Community Survey

Chart LTSS-9 shows that when asked about the greatest need from a variety of services, in 2012, the greatest number of responses was for Homemaker Services for People who are Elderly/Disabled. (This information is also shown in Chart HHD-1 in a previous section.)

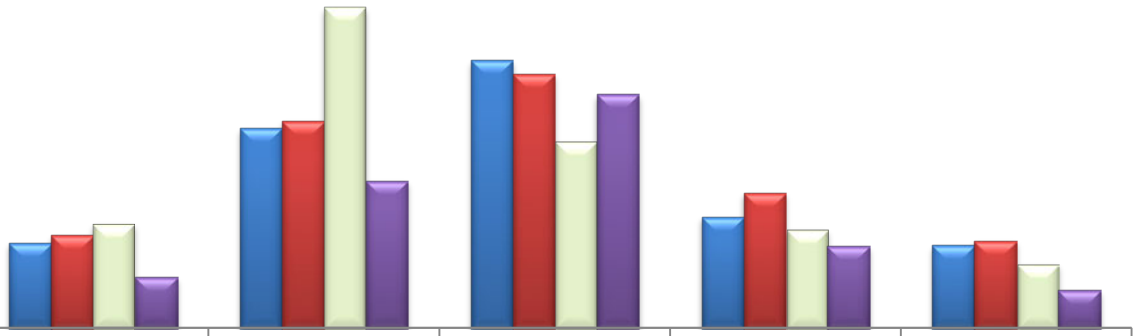
Chart LTSS-9: Greatest Need in Home and Community Based Services
Grassroots Community Survey, 2012



Source: 2012 Grassroots Community Survey

Chart LTSS-10 shows the responses for all 4 years in which the survey was conducted. Except for 2011 when Help Paying for Child Care was the top need identified, Homemaker Services for Elderly or Disabled People was the highest ranked need.

Chart LTSS-10: Greatest Need in Home and Community Based Services (Seniors, Child Care)
Grassroots Community Survey, 2009-2012



	Child Care Closer to My Home	Help Paying for Child Care	Homemaker Services for Elderly or Disabled People	Homemaker Services for Relative Caregivers (raising the children of relatives)	More Infant Child Care
2009	11.0%	25.7%	34.5%	14.3%	10.6%
2010	12.0%	26.7%	32.8%	17.4%	11.2%
2011	13.52%	41.30%	24.07%	12.78%	8.33%
2012	6.5%	19.0%	30.1%	10.5%	4.8%

Source: 2012 Grassroots Community Survey

Additional information about Long-Term Support and Services:

Center for Health Care Strategies, Inc. *Profiles of State Innovations Roadmap for Managing Long-Term Support and Services*
http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf

National Health Policy Forum, *The Basics, National Spending for Long-Term Support and Services*
http://www.nhpf.org/library/the-basics/Basics_LongTermServicesSupports_02-23-12.pdf

National Council on Aging, *Long-Term Support and Services*
http://www.ncoa.org/public-policy-action/long-term-services--supports/

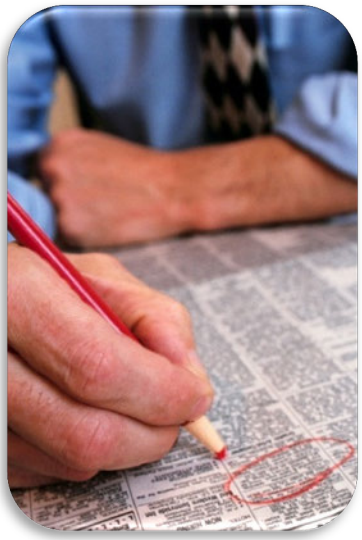
Workforce and Economic Opportunity

Key Findings

- **During the past year, Davidson County's unemployment rate has decreased, but remains higher than prerecession levels. With the service industry as the leading job creator (with many low paying jobs), the job prospects for workers with limited skills have improved little.**
- **Unemployment rates are not the same for all demographic groups, and the degree of the job losses varied. Younger workers (ages 16-24) of all races have been disproportionately impacted by the great recession more than any other group. In addition, the unemployment rate for people with disabilities is higher than for persons without disabilities.**
- **Educational attainment enhances the chances to obtain employment and is linked to adequate, and in some cases higher earnings. Workers with higher educational attainment have experienced lower unemployment rates compared to those with lower levels of education.**
- **Banking and mainstream financial transactions are essential to many families that need building financial assets and accumulate wealth. Low-income adults that do not use banking relationships spend exorbitant fees paying back debts associated with predatory lending.**

Unemployment

As reported in the *Job Openings and Labor Turnover Survey Highlights* in September 2012, the U.S. Bureau of Labor Statistics noted that the ratio between the unemployment rate and the number of job openings fluctuated over time. They reported that when the recession began in late 2007, there were 1.8 unemployed persons per job opening, which had risen to 6.2 when the recession ended about 18 months later. In September 2012, the ratio was 3.3 unemployed persons per job opening. http://www.bls.gov/web/jolts/jlt_labstatgraphs.pdf

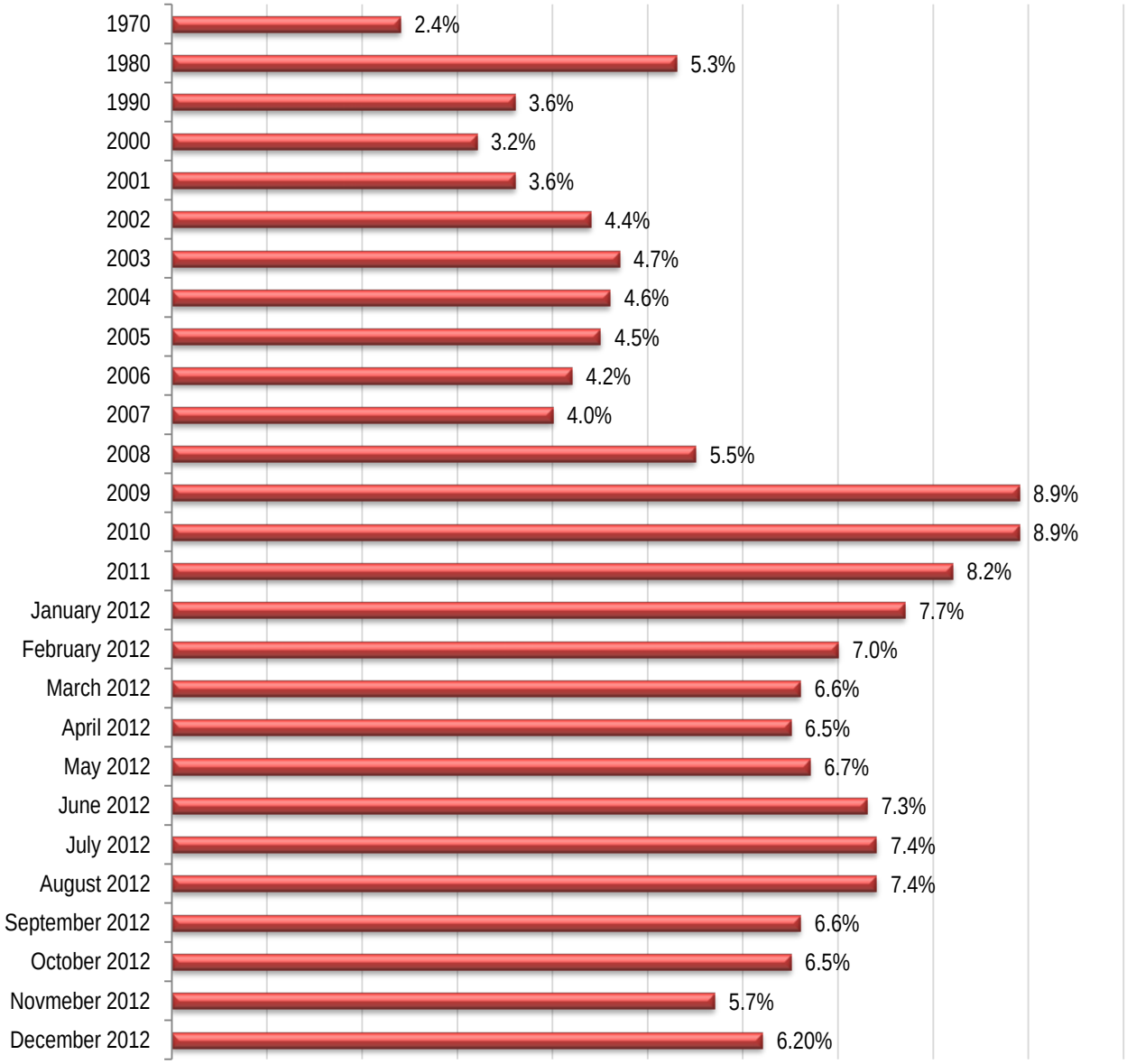


The recession exacerbated pre-existing conditions in the labor market that were already affecting employability and the earnings of the low-skilled workforce. Some studies report that the longer a person remains unemployed, the longer it takes to find suitable employment that would approximate the earning level of previous employment.

Most of the low-income workers who also are low-skilled workers have been facing a challenge in obtaining jobs. As shown in Chart W-1, the unemployment rate dropped to 5.7% in November 2012, the lowest rate during the previous three years. There was a slight increase to 6.2% in December 2012, but it is still much lower than for 2009-2010. Decreasing rates are indicative of an improving economy and there may continue to be fluctuations. However, many workers who lost their jobs during the Great Recession remain unemployed.

Chart W-1: Unemployment Rate

Davidson County, 1970 - December 2012

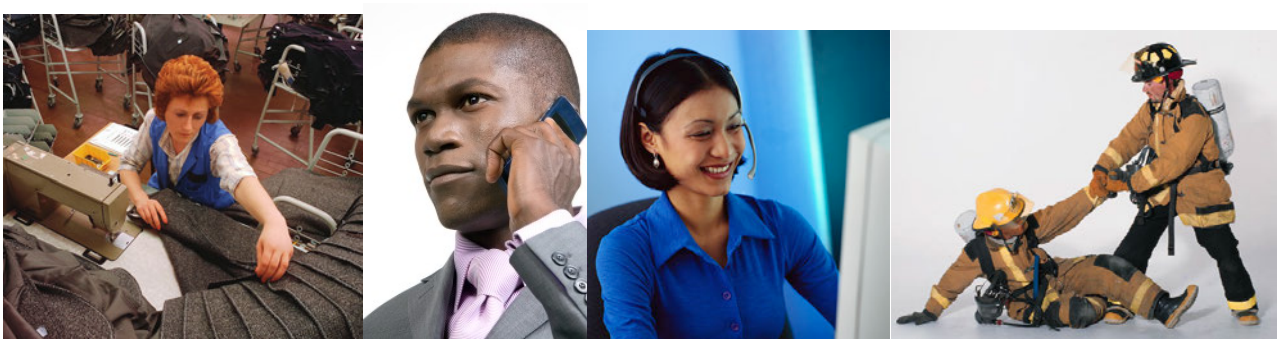


Source: Tennessee Department of Labor and Workforce Development

A report by the Hamilton Project, *What is Happening to America's Less-Skilled Workers,* notes that technological changes in the workplace, globalization, decline in union membership, and slowing increase in educational attainment are the main culprits of these diminishing opportunities. http://www.hamiltonproject.org/files/downloads_and_links/1110_jobs_men.pdf

Unemployment rates are not the same for all demographic groups. Younger workers (ages 16-24) of all races have been disproportionately impacted by the great recession more than any other group.

A report by the Hamilton Project, *The Long-Term Effects of the Great Recession for America's Youth*, finds that America's youngest workers have been hit hardest by the Great Recession. The report attributes some of this to many young workers entering the job market at a time of limited job opportunities. There are few job openings, in addition to older workers may delay retirement due to the impact of the recession on their wealth.
http://www.hamiltonproject.org/files/downloads_and_links/0810_jobs_youth.pdf



According to the U. S. Census Bureau's 2011 American Community Survey, the unemployment rate for black males in Davidson County between the ages of 16-24 was 23.0%, which is significantly lower than in 2010 when it was 36.4%.

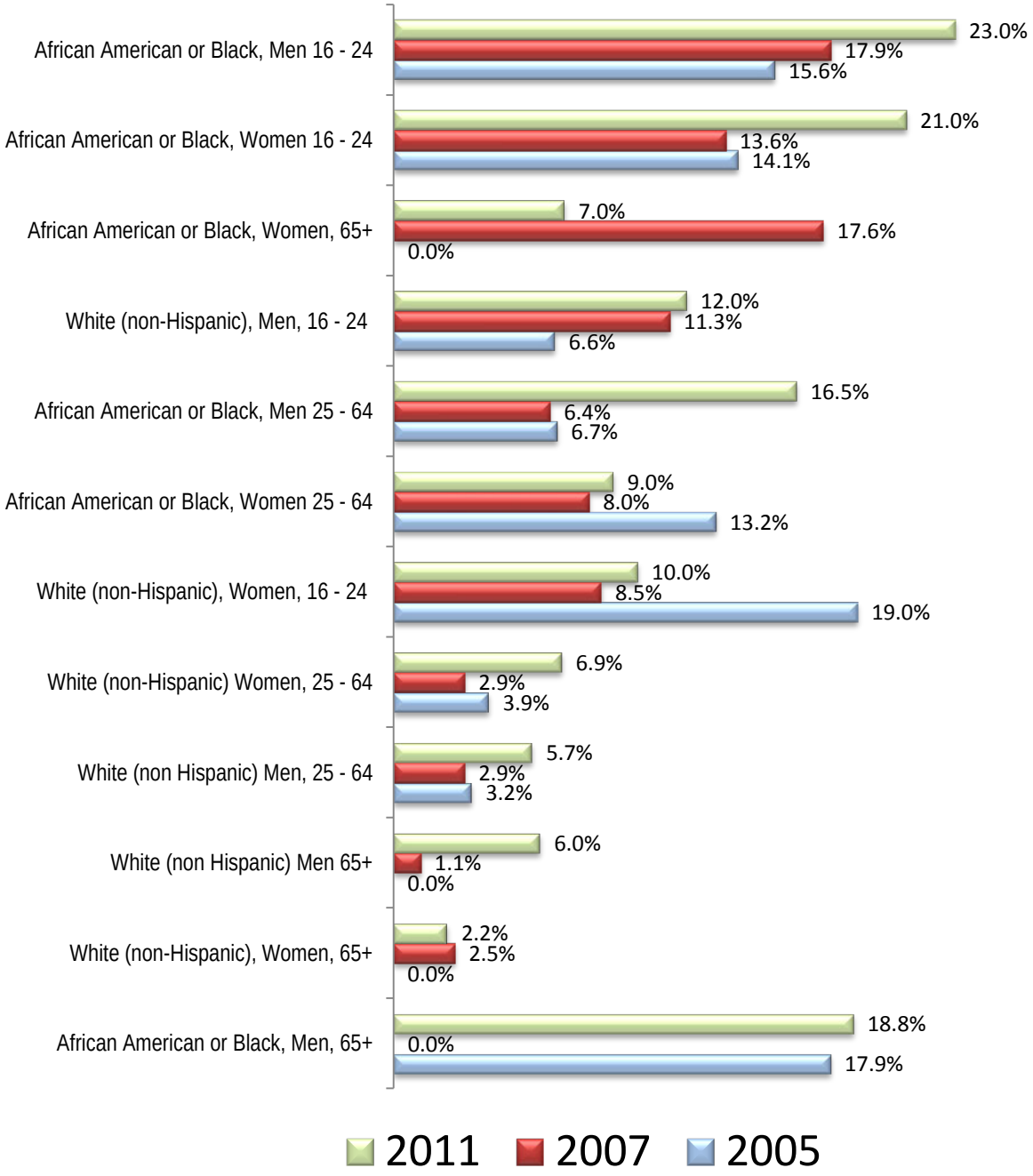
It is important to note that unemployment for this group is about three times that of the Davidson County's overall unemployment of 8.2% in 2011. The unemployment rate for black females in the same age group is 21.0%.

As Chart W-2 indicates, African Americans of both genders and all working ages are disproportionately impacted compared to other ethnic groups. For example, the unemployment rate in 2011 for African American males age 25-64 was 16.5%, twice the Davidson County unemployment rate and almost three times that for white males in the same age group, 5.7%.

Of particular note is the significant increase of the unemployment rate for African American males age 65 and over, a rise of almost 19.0%. Part of this increase could be attributed to the return of this age group to the labor force as the economy is improving, and perhaps their desire to continue working as their assets were impacted by the financial upheaval of the great recession.

Among the white population, as like the last few years, both white men and women ages 16-24 have the highest unemployment rate of 12.0% and 10.0% respectively.

Chart W-2: Percentage of Unemployment by Race and Gender
Davidson County, 2005, 2007, 2011

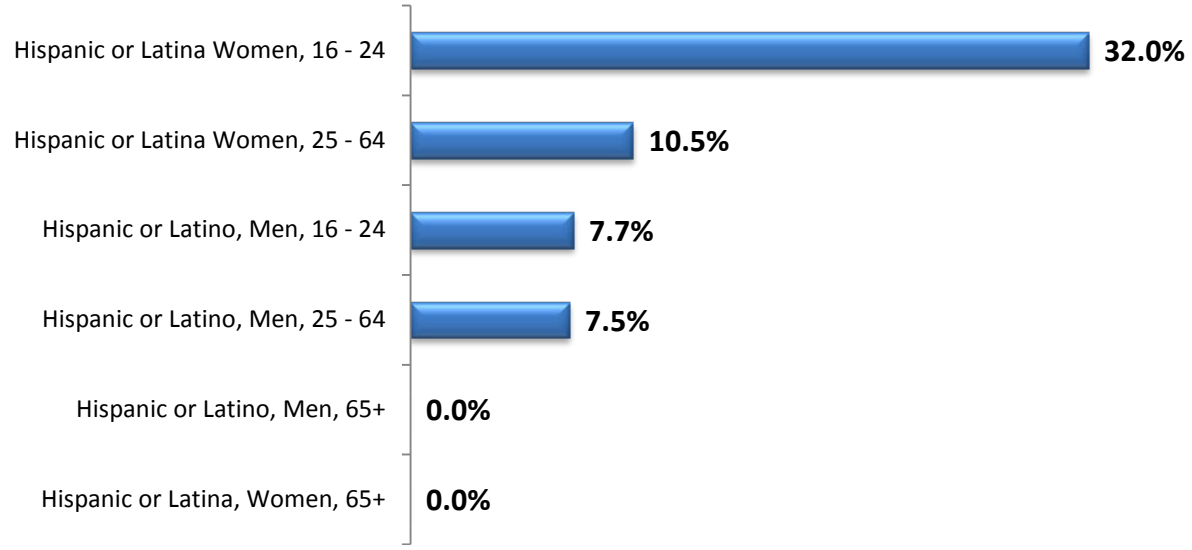


Source: The American Community Survey 2005, 2007, and 2011

It has been reported in several nationwide studies that the people who remained unemployed for the longest period experienced an increase in poverty. According to the Urban Institute's *Unemployment and Recovery Project*, poverty in 2011 increased with the number of weeks a person remained unemployed. In 2011, the poverty rate of the long-term unemployed (27 weeks and more) was 42.4%, more than three times the rate of those with no unemployment (12.4%). Among the long-term unemployed, poverty was highest among single-parent households unemployed for more than 26 weeks. About 74.0% of single parents with long-term unemployment were living below the poverty line in 2011.
http://www.urban.org/UploadedPDF/412652-Poverty-and-Unemployment.pdf

By looking at the unemployment rate for the Davidson County Hispanic population, a different data set was available at the county level from the American Community Survey. Chart W-3 shows the 2009-2011 3-year summary average unemployment for Davidson County Hispanic population.

Chart W-3: Unemployment Rate, Hispanic Population Categories
Davidson County 2009-2011



Source: U.S. Census Bureau, 2009-2011 American Community Survey

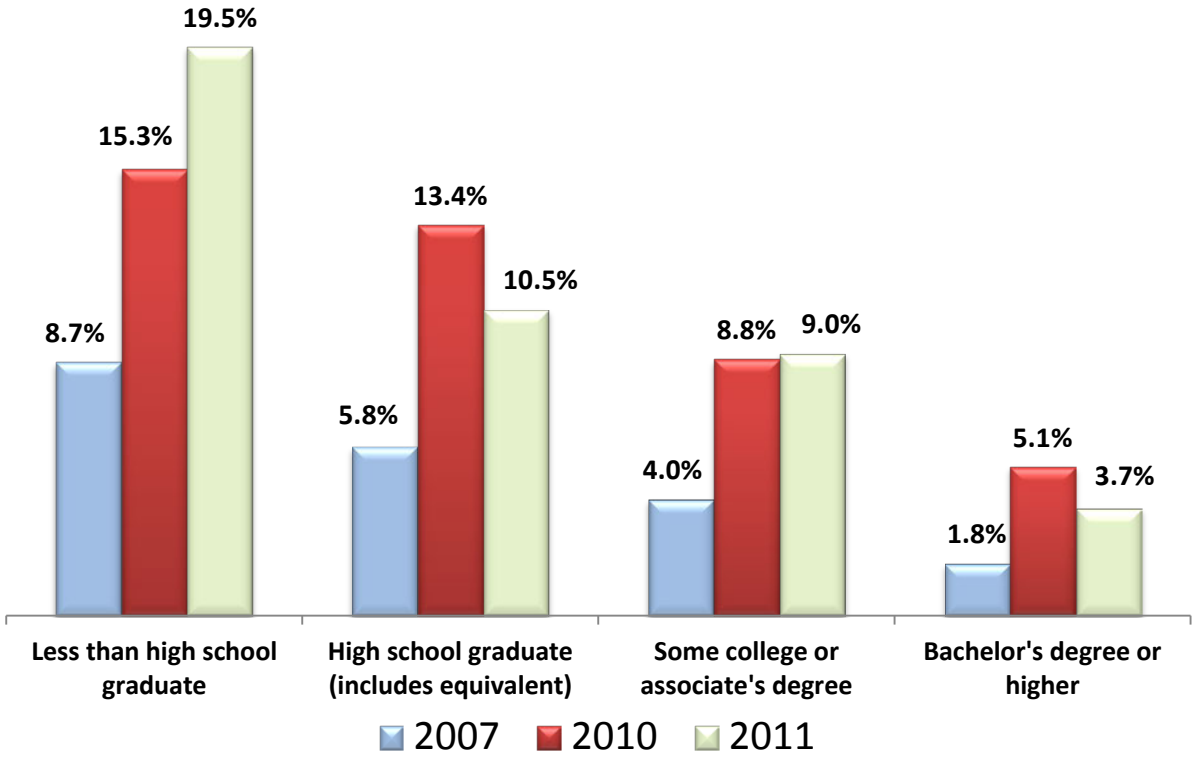
Unemployment rates among the Davidson County Hispanic population show a similar disparity. Hispanic men ages 25-64 have unemployment rate (7.5%) less than that of Davidson County in 2011 (8.2%), while the rate is much higher for Hispanic/Latina women. The females in the 16-24 age group experienced the highest unemployment rate of 32.0%, an increase of 12.0% points compared to the previous three-year average (2007-2009).

Throughout the nation, the unemployment rate continues to remain high. Many analysts predict that the unemployed workers will have difficulty in regaining employment as the sectors that employed them are shrinking. For workers in some sectors, their skills could become inadequate for a changing economy that requires enhanced training or abilities.

Disparity in unemployment rates was not reflected only in age, ethnicity, and race. Persons with lower educational attainment are more likely to experience and remain unemployed. Chart W-4 shows unemployment rates and educational attainment before the Great Recession started and almost two years after it ended. The unemployment rate in Davidson County for workers with less than high school increased from 8.7% in 2007 to 19.5% in 2011, and workers with high school education experienced an unemployment rate of 5.8% to 10.5% in the same period.

Chart W-4: Unemployment and Educational Attainment

Davidson County, 2007, 2010, and 2011



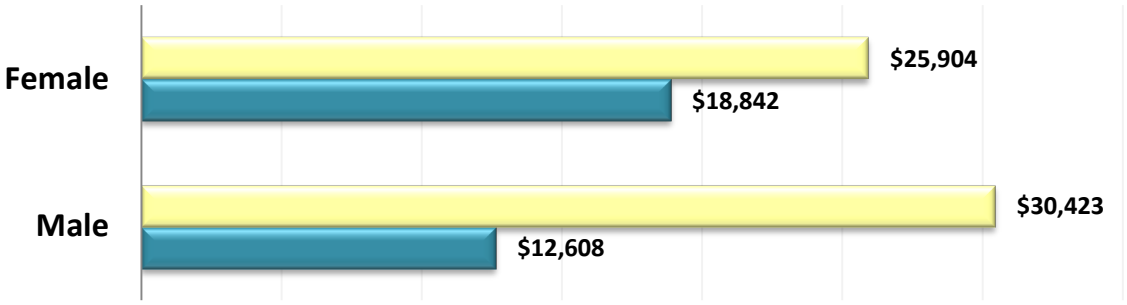
Source: American Community Survey, 2007, 2010, and 2011

As reported in previous Community Needs Evaluations, the economy has continued to change through global competition and technological change, and higher educational attainment is necessary to build the skills that would be more valuable to employment. In addition to ethnic minorities, youth, and those who have lower educational attainment, persons with disabilities are also less likely to be employed than persons without disabilities.

Both income and rate of employment are higher for those who do not have a disability. Chart W-5 shows that males and females who do not have a disability have a significantly higher median income. The median income for males is more than twice as much as for males who do not have a disability.

Chart W-5: Median Income With and Without A Disability, By Gender

Davidson County, 2011



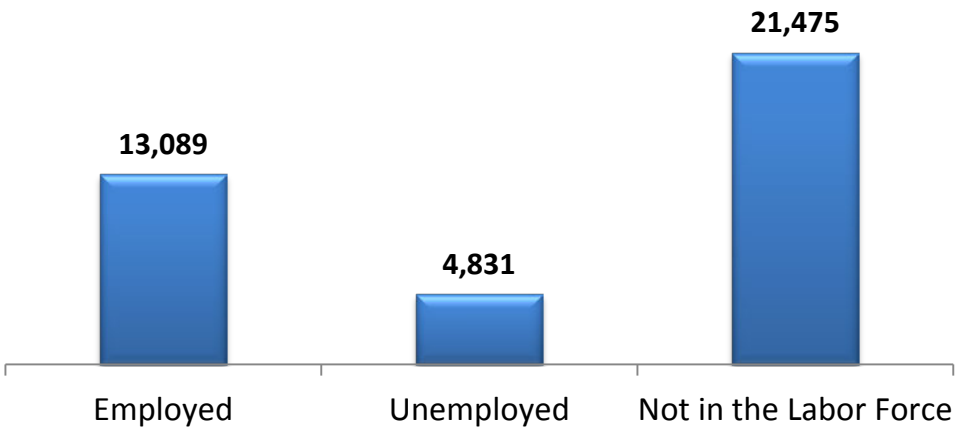
	Male	Female
With No Disability	$30,423	$25,904
With A Disability	$12,608	$18,842

Source: 2011 American Community Survey

Chart W-6 shows that there were 39,395 people ages 18-64 with disabilities in Davidson County in 2011. The unemployment rate for people with disabilities was 27.0%, more than three times the 8.0% rate for people without disabilities.

Chart W-6: Employment Status, Ages 18-64 with a Disability

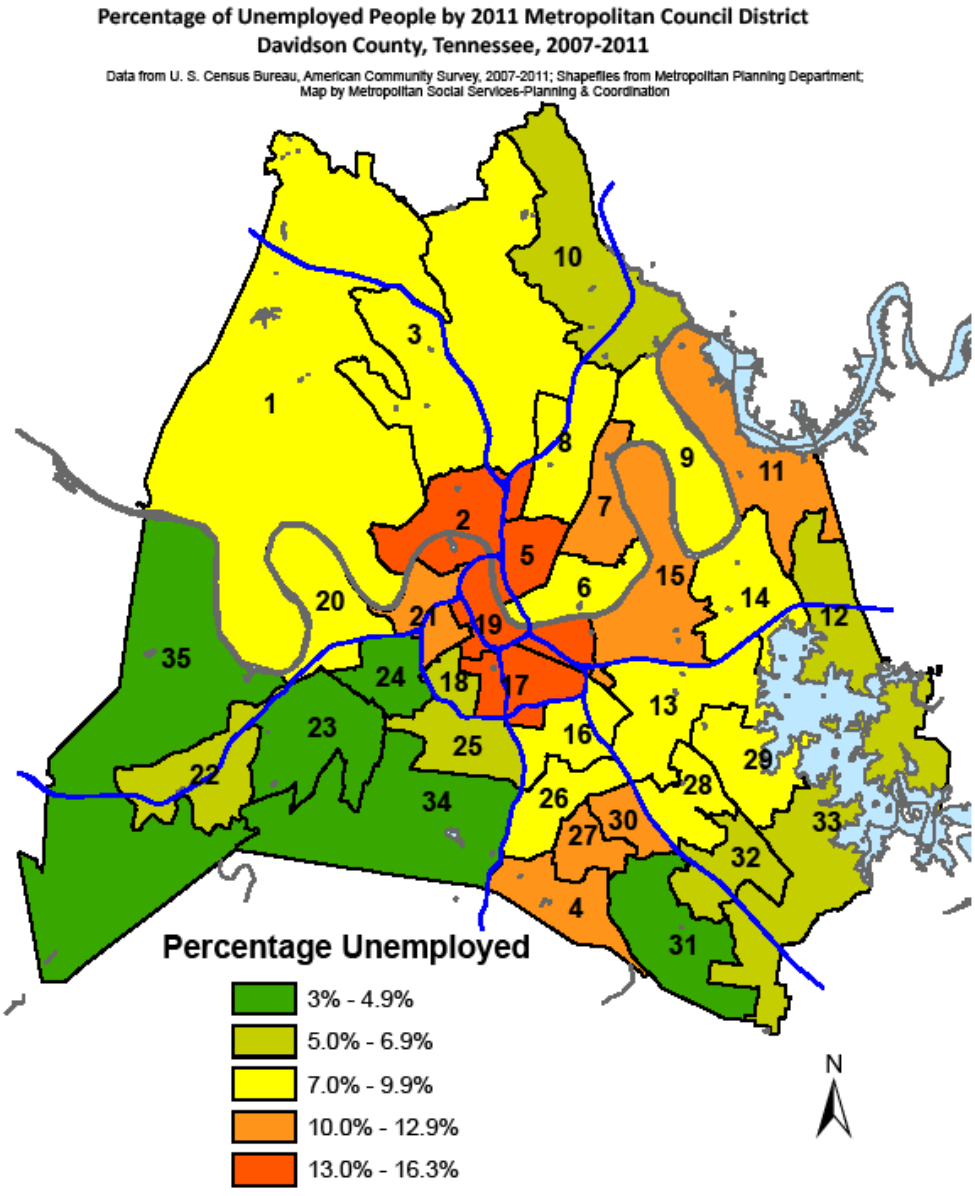
Davidson County, 2011



Source: 2011 American Community Survey

As shown in the map using data from the 2007-2011 American Community Survey 5-Year Summary, there is a wide variation in the percentage of unemployed people by Metropolitan Council District. Unemployment ranges from 3.0% in Metro Council District 34 up to 16.3% in Metro Council District 2.

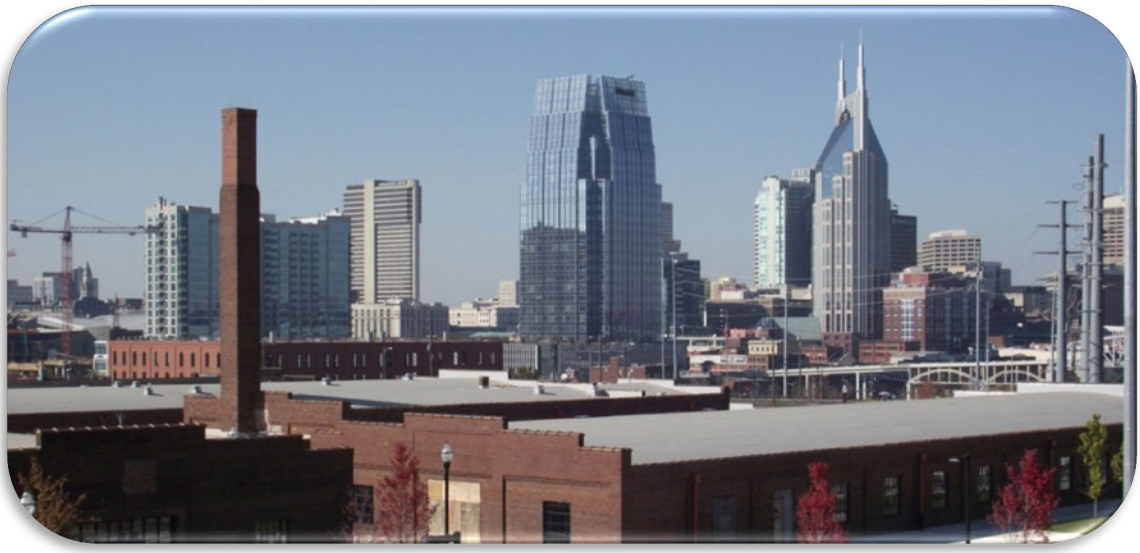
Three Districts (2, 19 and 5, in decreasing order) have unemployment greater than 15%. Five Districts have unemployment lower than 5% (23, 31, 35, 24 and 34).



The highest areas of unemployment (13.0% and above) are near the central city area, but those with poverty between 10.0-12.9% are across the southern and eastern parts of Davidson County. A few years ago, the Congressional Budget Office projected through 2017 that the "natural" unemployment rate was about 5%. Economists are not sure of how the recession may have affected the natural rate or how it may change in the future.

Economic conditions have gradually improved recently. As a result, employment in Davidson County has improved significantly since the end of the Great Recession and unemployment is almost back to the pre-recession levels. In November 2012, the Davidson County economy employed 311,770 with unemployment rate of 5.7%. That is 19,580 more people employed and 3.2% less unemployment rate compared to 2009, when the Great Recession had its worst impact on the economy, in which Nashville economy was employing 292,460 workers with unemployment rate of 8.9%.

In July 2012, the Urban Institute's *Job Polarization and the Great Recession* described the decreased employment and earnings growth experienced by middle-skill workers. Job polarization is often related to new technologies and offshoring manufacturing jobs. This decreases the number of middle-skill jobs, while usually retaining high-skill jobs, and began several years before the recession. Those with lower skills are usually those who work for the lowest wages, and the report indicates that those at greatest risk of unemployment are low wage workers. Middle wage workers are at more risk of unemployment than those with the highest wages. Job polarization was not increased by the recession, but is likely to continue rising, creating additional challenges for middle-skill workers.
http://www.urban.org/UploadedPDF/412680-Job-Polarization-and-the-Great-Recession.pdf

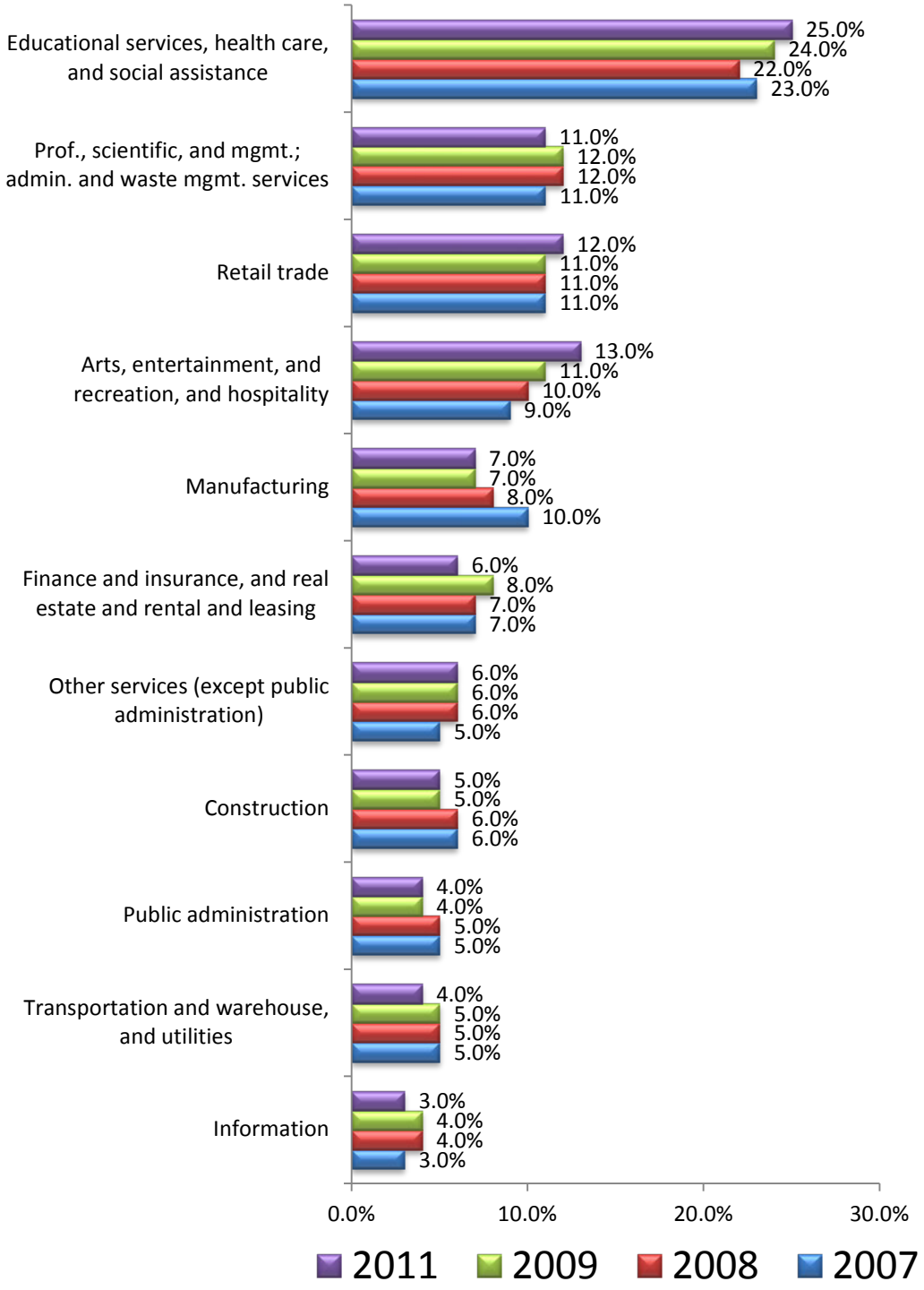


Leading Sectors

The Nashville Metropolitan Statistical Area (MSA) continues to have a diversified economy that supports a balanced employment in all its sectors, and they all contribute to its growth. As technology improves productivity, some sectors including manufacturing continue contributing to the economy despite experiencing shrinking employment. As shown in Chart W-7, education, health care, and social assistance was the leading industry category in the last five years in Davidson County at 25.0%. While retail trade, professional, scientific, management, administrative, and waste management were consistently stable, while the arts, entertainment, recreation, and hospitality have gained ground and are now the second leading industry category of employed people 16 and older at 13.0%.

Chart W-7: Percentage of Employed People 16 Years and Older

By Selected Industry, Davidson County, 2007, 2008, 2009, 2011



Source: American Community Survey 2007, 2008, 2009, and 2011

According to the 2011 American Community Survey, among the more common occupations for the civilian employed population 16 years and over in Davidson County were management, business, science, and arts occupations (39.1%), service occupations (18%), sales and office occupations (26.6%), and production, transportation, and material moving occupations (9.5%).

Economic Opportunity

Many low-income households struggle to meet their basic financial needs. Many low wage workers face challenges in managing their financial resources and avoiding financial instability. There is a need to increase access to less costly financial literacy and counseling. There is a need to protect low-income struggling families from predatory and deceptive practices that would lead them to irreparable financial disaster.

About one in four households in the Nashville Metropolitan Statistical Area are either unbanked or under-banked, according to the Federal Deposit Insurance Corporation. Many of these low-income households spend a higher proportion of their earnings on basic services and goods, including housing, childcare, transportation, etc., which presents a significant barrier to saving and building assets. However, there are opportunities for wealth building that need to be expanded to low-income households.

An essential program for low-income workers is the Earned Income Tax Credit (EITC), which reduces the amount of tax owed and ensures a significant refund. Financial education is another tool that can assist low-income families in making informed decisions on financial transactions that would help them avoid predatory lending practices.

Educational Attainment

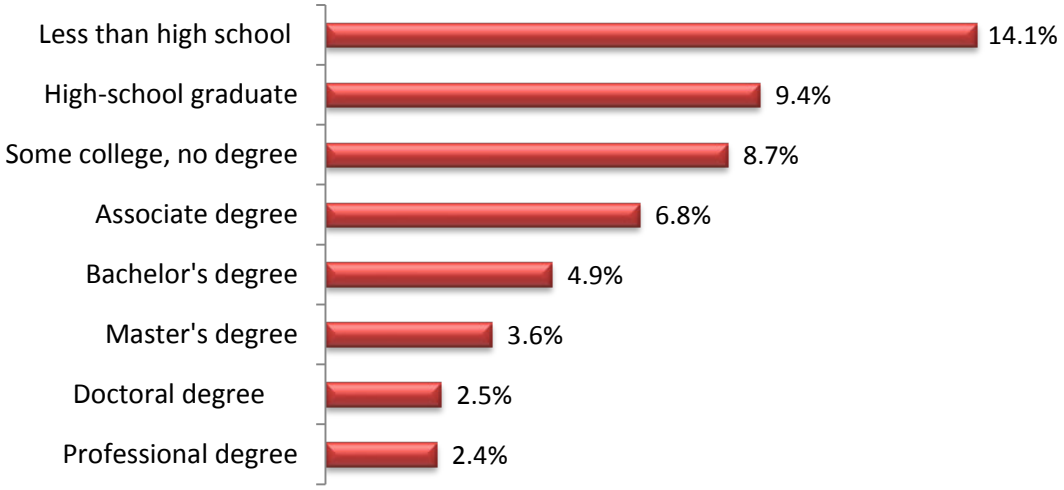
Greater educational attainment enhances the likelihood of obtaining employment as well as higher earnings.

Even when the Great Recession left many communities with higher unemployment rates, the workers with higher educational attainment experienced lower unemployment rates compared to those with lower levels of education.

As Chart W-8 shows in 2011, people with the highest educational attainment were the least likely to be unemployed. For example, the unemployment rate for people with less than high school diploma was 14.1%, while the unemployment rate for people with a bachelor's degree was 4.9.

Chart W-8: Unemployment Rate by Educational Level

U.S., 2011

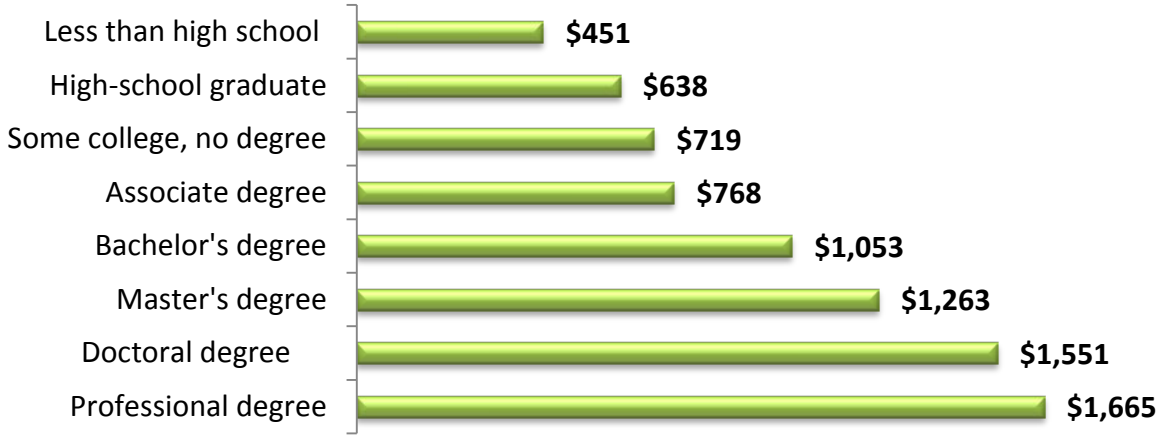


Source: Bureau of Labor Statistics, Current Population Survey

Higher educational attainment is generally associated with higher earnings, and that is a potential benefit to economic success. Chart W-9 shows the variation in Median Weekly Earnings by level of educational attainment for workers aged 25 and older. Median Weekly Earnings are higher for those with more education, in addition to the lower unemployment rate in the previous chart. The lowest median weekly earnings ranged of $451 for workers with less than high school, ranging to the highest of $1,665 for those with professional degree. Those with bachelor's degrees earned 65% more than worker with a high school diploma.

Chart W-9: Median Weekly Earnings by Educational Attainment

U.S., 2011



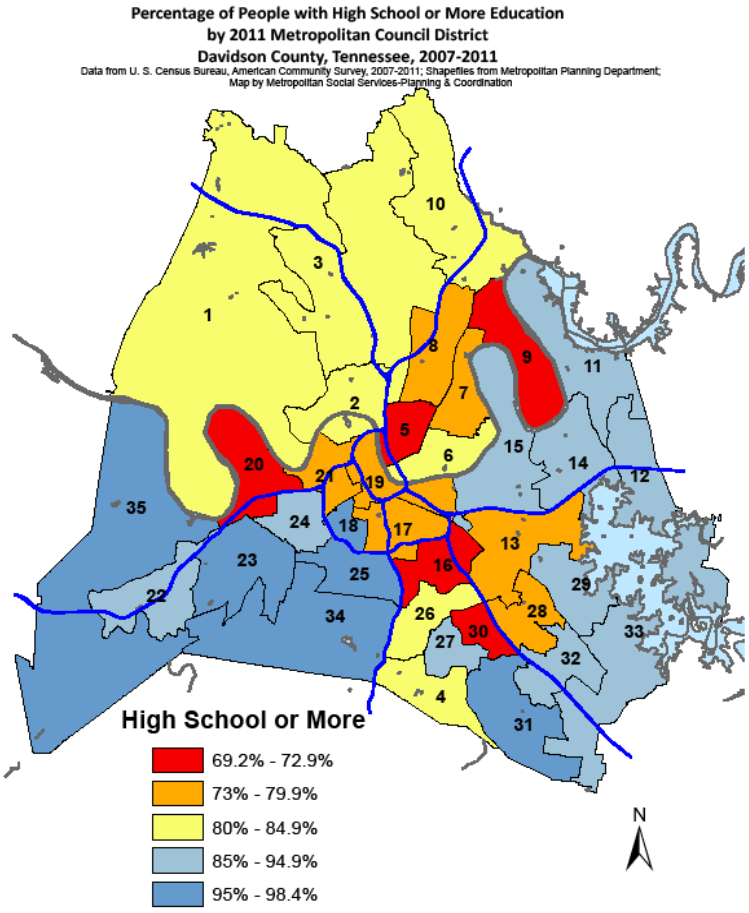
Source: Bureau of Labor Statistics, Current Population Survey

An elevated level of educational attainment of the adult population is an indicator of an educated workforce as well as an individual's opportunity to have gainful employment with a higher level of income. *Work-Life Earnings by Field of Degree and Occupation for People With a Bachelor's Degree* (2011) by the Census Bureau projected how various occupations would vary for workers who had attained a bachelor's degree (but without advanced degrees). It found that higher work-life earnings were often related to engineering, computers and math.

Work-Life Earnings also projected the synthetic work-life earnings (expected earnings over 40 years for persons aged 25-64 who worked full-time, year around) and shows a substantial increase for each level of education attained.

- Less than 8th grade - $936,000
- 9th to 12th grade - $1,099,000
- High school graduate - $1,371,000
- Some college - $1,632,000
- Associate's degree - $1,813,000
- Bachelor's degree - $2,422,000
- Master's degree - $2,834,000
- Professional degree - $4,159,000
- Doctorate degree - $3,525,000

http://www.census.gov/prod/2012pubs/acsbr11-04.pdf

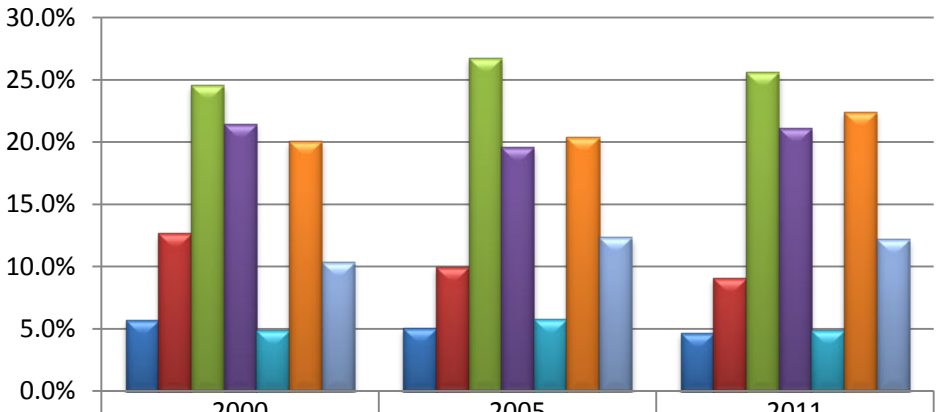


The map shows the percentage of people who have at least a high school diploma or more by Metropolitan Council Districts. The percentage of people with at least a high school education ranges from 69.2% in Metro Council District 5 up to 98.4% in Metro Council District 25.

Educational attainment varies in different areas. Chart W-10 compares the percentage of people in Davidson County who attained specific levels of education by year. The percentage of people in Davidson County with less than a high school diploma decreased from 18.4% in 2000 to 13.8% in 2011.

The percentage of people with a bachelor's degree and higher increased from 30.5% to 34.6% from 2000 to 2011, which is the group the gained the most, an increase of 4.1%.

Chart W-10: Educational Attainment
Davidson County, 2000, 2005, and 2011

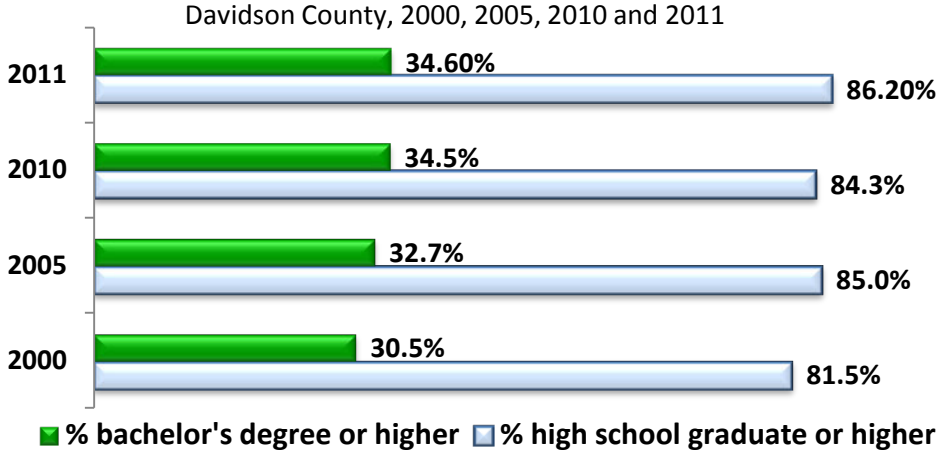


	2000	2005	2011
Less than 9th grade	5.7%	5.0%	4.7%
9th to 12th grade, no diploma	12.7%	10.0%	9.1%
High school diploma or equivalency	24.6%	26.8%	25.6%
Some college, no degree	21.5%	19.6%	21.1%
Associate's degree	4.9%	5.8%	4.9%
Bachelor's degree	20.1%	20.4%	22.4%
Graduate or professional degree	10.4%	12.4%	12.2%

Source: U.S. Census Bureau (2000 Census, 2005 and 2011 ACS)

Chart W-11 groups the educational levels together to better demonstrate the changes in each category across the four selected years of 2000, 2005, 2010, and 2011.

Chart W-11: Educational Attainment
Davidson County, 2000, 2005, 2010 and 2011

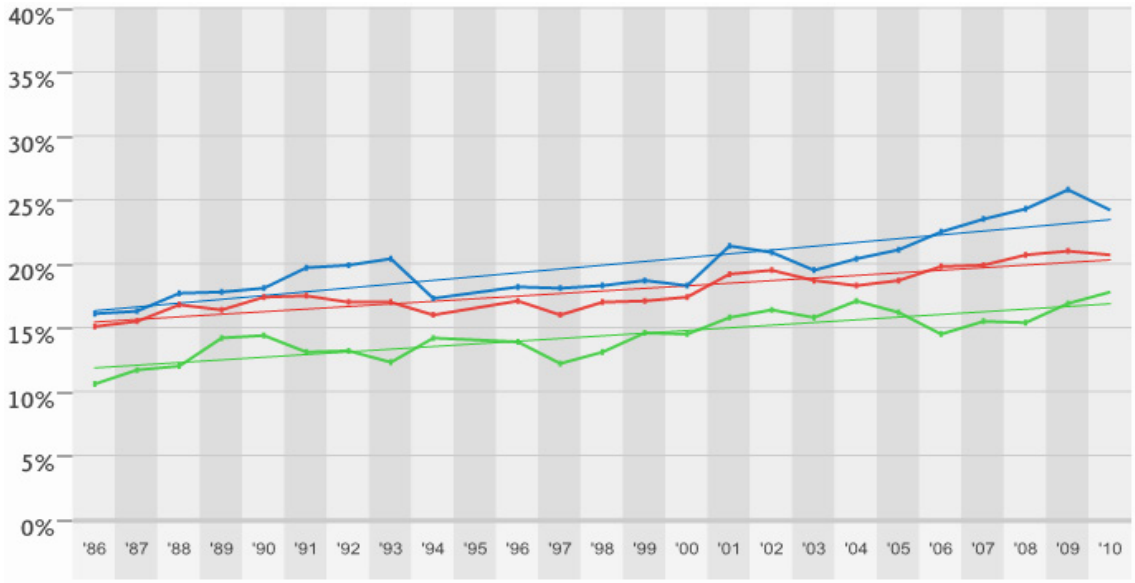


Source: U.S. Census Bureau (2000 Census, 2005, 2010, 2011 American Community Survey)

As described earlier in this document, those who experience economic insecurity are those who have lost at least 25% of their income (or their out-of-pocket medical expenses increased to the same extent) without adequate financial resources to compensate for the loss until their income is restored to the previous level. This chart shows that among those ages 18-40, those without a high school education are more likely to experience economic insecurity than those with college degrees, with the category of all Americans falling in between.

Chart W-12 shows the Economic Security Index's November 2012 update, which indicates, "Almost five years after the start of the Great Recession, Americans' household resources are beginning to stabilize." It described the significant decline in economic insecurity from 20.5% in 2009 to 18.9% in 2011.
http://economicsecurityindex.org/assets/esiupdate_11_1_2012.pdf

Chart W-12: Level of Economic Security by Educational Attainment
U. S., 1986-2010



Source: Economic Opportunity Index http://economicsecurityindex.org/

Earned Income Tax Credit

The Earned Income Tax Credit (EITC) is an effective tool in reducing poverty. It is a federal income tax credit for workers whose income is low enough to meet the eligibility requirements. Taxpayers who qualify and claim the credits either pay less federal tax, pay no tax or receive a refund.

According to the Internal Revenue Services (IRS), in 2012 working families with children that have annual incomes below about $36,900 to $50,300 (depending on marital status and the number of dependent children) may be eligible for the federal EITC. Working people with no children with

incomes below $13, 900 and married couples with incomes below $19,200 are generally eligible for the EITC tax credit.

Many advocates identify EITC as a method to reduce poverty by supplementing the earnings of workers who have low wages. However, according to the Nashville Alliance for Financial independence (NAFI), many low-income families who may be eligible for EITC are unaware that they qualify for this credit.

According to the IRS, in 2011 there were 650,098 people in Tennessee who filed EITC and obtained $1.5 billion in refunds, with an average refund of $2,311. The table below shows the number of EITC returns filed in Davidson County since 2007. For example, in 2011, there were 66,753 EITC returns filed in Davidson County.

EITC Returns Filed	2007	2008	2009	2010	2011
Number of people	63,459	70,652	70,138	66,043	66,753

Mainstream Financial Transactions:

In order for families to build financial assets and accumulate wealth, it is necessary to have access to mainstream (traditional) banking and financial services. Low-income adults that do not use banking relationships spend exorbitant fees paying back debts associated with predatory lending.

The unbanked are defined as those without an account at a bank or other financial institution. The under-banked have a checking or savings account, but they utilize alternative financial services (costing additional fees) rather than mainstream services.

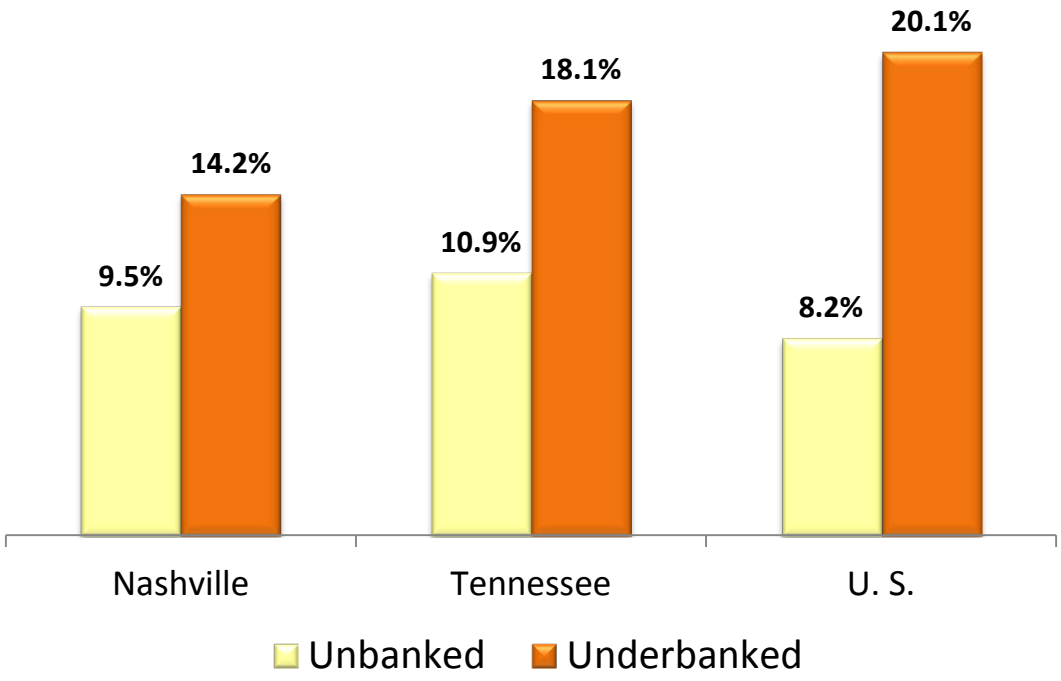
Outside the mainstream financial institutions, low-income people may turn to alternative expensive transactions, such as rapid anticipation loans for tax refunds, payday loans, rent-to-own stores, check cashing, pawn shops, auto title loans, pre-paid debit cards with high fees, and other lenders.

There are various reasons that the unbanked or under-banked may use these more costly alternatives. For example, some report having previous bad experiences with banks, believing they do not have enough money to use a traditional bank, not understanding the benefits of mainstream banking services, language barriers due to limited English proficiency and various other reasons as to why they do not use banks.

As Chart W-13 shows, according to the Federal Deposit Insurance Corporation (FDIC), in 2011, 23.7% of Nashville Metropolitan Statistical Area (MSA) households were unbanked and under-banked compared to 29% and 28.3% for Tennessee and the U.S., respectively.

Chart W-13: Percentage of Unbanked and Underbanked

Davidson County, Tennessee, U. S., 2011



Source: Federal Deposit insurance Corporation (FDIC)

Grassroots Community Survey

As high as unemployment has been since the Great Recession began five years ago, it is no surprise that Help Finding a Job/Job Placement has been the most frequently identified category in each of the four years the survey was completed. As shown in Chart W-14, almost a quarter, or 24.4% of respondents to the 2012 Grassroots Community Survey, when asked to identify the greatest needs in Workforce and Economic Opportunity, chose Help Finding a job/Job Placement as the most frequently identified need.

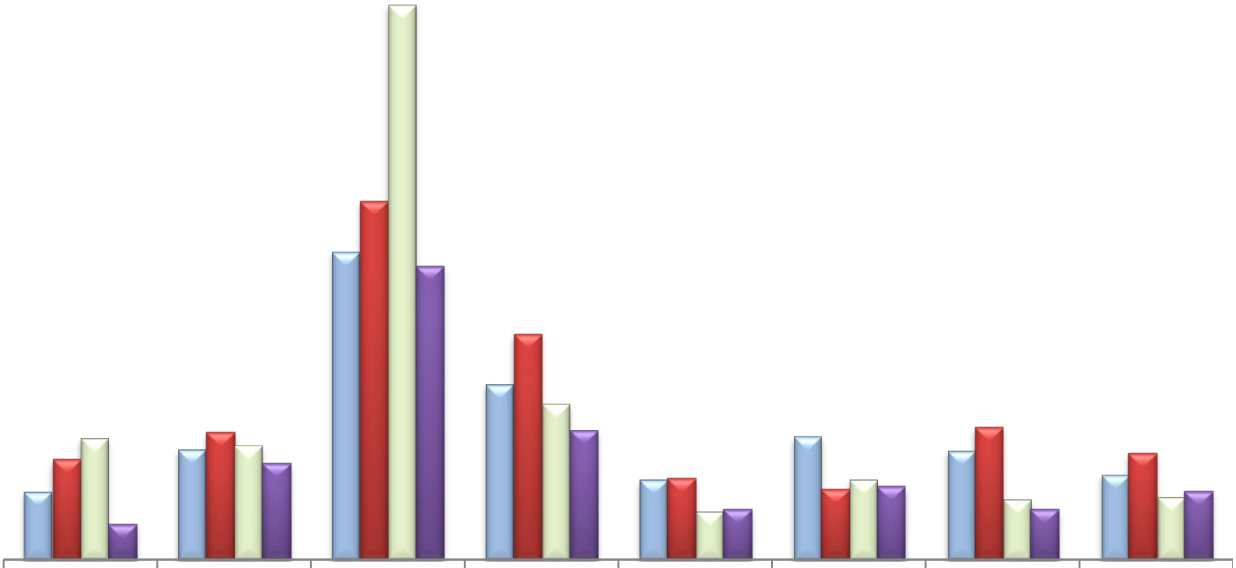
Although there was a decrease in the percentage identifying the Help Finding a Job/Job Placement from 2011 to 2012, it is by far the most frequently identified need for all years in which the survey was conducted. There are still low-skilled workers who fear that their long duration of unemployment would make it difficult to return to the workforce, but the decrease could be an indicator of an improving economy.

There was a significant decrease in 2012 in the number of respondents who indicated the need for College or Junior College. A possible reason for this could be that the unemployed are more concerned about their financial stability and need for immediate employment.

The recession created significant challenges for many low-skilled workers in securing employment. This population continues to be out of work and spend longer periods of time looking for work. The longer the long-term unemployed remain discouraged, the more they realize that participating in some kind of employment services would facilitate their return to the workforce. They expect that employment support would help them re-tool their job readiness skills and also link them to employers that have recruiting relationships with community organizations.

Chart W-14 : Greatest Need in Workforce and Economic Opportunity

Grassroots Community Survey, 2009-2012



	College or Junior College	GED Assistance, Adult Education	Help Finding a Job/Job Placement	Job Training	Life Skills Counseling, Case Management	Public Benefits, including SSI, SSA, TANF, etc.	Training About Money and Finances	Vocational Training
2009	5.7%	9.2%	25.6%	14.6%	6.7%	10.3%	9.1%	7.1%
2010	8.3%	10.6%	29.8%	18.7%	6.8%	5.9%	11.0%	8.9%
2011	10.16%	9.55%	46.14%	13.01%	4.07%	6.71%	5.08%	5.28%
2012	3.0%	8.0%	24.4%	10.7%	4.2%	6.1%	4.2%	5.7%

Source: 2009-2012 Grassroots Community Survey

Evidence-Based Practices

As organizations provide social and human services, it is important for them to use Evidence-Based Practices of relevant professions. Because the environment, needs and resources, evolve, continuing efforts are needed to develop and maintain Evidence-Based Practices, which involve intentional use of the current best evidence to make decisions. It includes the use of proven processes and techniques over those for that lack evidence to support successful replication. Best practices are those that achieve the desired outcome while also being cost-effective.

These practices could be implemented effectively through knowledge management in organizations, using both tacit knowledge (personal experience) and explicit knowledge (evidence). Knowledge management involves gathering, distributing and effectively utilizing knowledge, preferably with an integrated approach to include multiple sources.

While some professions have universal industry standards, social/human service delivery does not. In the absence of industry standards, it is essential for organizations to consider the evidence and best practice examples that are available. The importance of using Evidence-Based Practices was described in the 2011 Community Needs Evaluation (pages 35-38), and each topical section included examples of best practices. For the 2012 edition, the material on using evidence to create best practices is consolidated in this section.

Background and Examples

An issue paper on *Evidence-Based Practices – Strategies for Incorporating EBPs into Service Systems* (Center for Innovative Practices, 2004) noted that Evidence-Based Practices could be incorporated into established systems of care. This combination strengthens each component to result in a more systematic and fiscally responsive system. It examined child and behavioral health to explore reasons organizations may have been reluctant to adopt Evidence-Based Practice, such as lack of knowledge, belief that the approach would not work for a particular population or community, lack of organizational commitment, unwillingness to change and inflexible requirements of funding sources.

Evidence-Based Practices suggested next steps to adopt and integrate Evidence-Based Practice into systems of care:

- Clinical and Practice Level
    - Identify the individuals/organizations that have a culture of change, progress, champion behavior and have high credibility and presence across stakeholders to further chronicle effective strategies and lessons learned.
    - To further continuous quality improvement and accountability, require provider-developed interventions or programs to collect and analyze outcome data for effectiveness
    - Bringing effective clinical practices "to scale"
- Policies that
    - Require local, community specific planning processes (based on data, needs, risks, protective factors, and assets) that guide the implementation, evaluation, re-engineering of local SOC and their components and plan for future reinvestment of dollars for sustainability
    - Develop state/local "centers of excellence" that provide expertise, technical assistance and planning assistance to move from policy to practice in specific Evidence-Based practices and/or with specific target populations
- Research that
    - Further investigates EBPs - what populations are the focus, relevance to the community, and needs assessment data
    - Identify effective family involvement strategies Supports the creation of state and local data bases to support that EBPs are effective "here at home"
    - Identifies the key outcome elements that make a difference to all stakeholders (including financial outcomes)…these will be key to sustainability and demonstrating success over time

http://www.dss.state.la.us/assets/docs/searchable/OS/CSoC/Issue_paper_EBP_patrick.pdf

The Child Welfare information Gateway of the U. S. Department of Health & Human Services reports that Evidence-Based Practice could be more effective when implemented in a way that closely reflects the original evaluated approach. They suggest that organizations should

- Gather as much information as possible (about implementations of similar practices)
- Provide for infrastructure and other needs (technical assistance with program developers, appropriate staff buy-in and belief in the practice, adequate resources)
- Build an evaluation plan (to measure ongoing effectiveness)
- Adapt with caution (without information about replication, it may be difficult to evaluate and identify how the model could be adapted)

https://www.childwelfare.gov/management/practice_improvement/evidence/implementing.cfm

Best Practices in Human Services: A Global Perspective (Council for Standards in Human Service Education, August 2011) explains that best practices are designed to "reduce the harm to people afflicted by poverty, mental illness, and developmental disabilities." It explains that human service education empowers students who will have the primary goal "to advocate and empower the consumer to realize his or her potential in a democratic participatory rather than a draconian helper-helped relationship."

Best Practices in Human Services discusses examples of alternative contemporary solutions human service professionals can use to promote the welfare and quality of life for those in need. This discipline emphasizes the need to think critically about issues and diversity, as well as the importance of seeking out promising approaches that would be most effective.
http://www.cshse.org/pdfs/Hagen_8-4-2011.pdf

Case management involves the "timely coordination of quality services to address a client's special needs in a cost-effective manner in order to promote positive outcomes," according to the Case Management Society of American *(Standards of Practice for Case Management, Revised 2010)*. These standards were first published in 1995 and applied primarily to health and are applicable to related services.

The 2010 standards emphasize:

- Minimizing fragmentation
- Using Evidence-Based Practice
- Navigating transitions of care
- Incorporating adherence guidelines and other standardized practice tools
- Expanding the interdisciplinary team in planning care
- Improving safety

The 2010 revision of *Standards of Practice* promotes case management credibility and complement current trends, while building on Evidence-Based guidelines. It focuses on the total individual, collaborative efforts to move the individual to self-care (independence) whenever possible, minimizing fragmentation of service delivery, while also using evidence-based guidelines in the daily practice of case management.
http://www.cmsa.org/Individual/MemberToolkit/StandardsofPractice/tabid/69/Default.aspx

The Challenges of Implementing Evidence-Based Practice: Ethical Considerations in Practice, Education, Policy and Research (Social Work and Society International Online Journal, 2009) described the evolution of social work from grassroots community movements to a complex network of formally trained professionals "promoting social research, education and practice."

The article suggested that Evidence-Based Practices (also used in medicine, education, etc.) provide a philosophy and process that combines well-researched interventions with clinical experience. It also

discussed the challenges faced by social workers, as well how organizations are challenged to assure that services are ethical, competent and use the best available intervention and are offered in the best way to benefit clients

Evidence-Based Practices encourage using knowledge from a variety of sources and using critical evaluation of data to make informed decisions. Evidence-Based Practices are the gold standard for many fields but lag behind in social work, possibly because of challenges such as overgeneralization of research findings, lack of relevant research, lack of time and capacity of practitioners (particularly related to data analysis) and organizational policies influenced by conflicting political or other ideological issues.
http://www.socwork.net/sws/article/view/76/335

While traditional practices may remain the foundation of service delivery, changes in the environment, the evolution of technology and knowledge acquisition provide the opportunity for strategic improvements and innovation.
http://www.dss.state.la.us/assets/docs/searchable/OS/CSoC/Issue_paper_EBP_patrick.pdf

The use of Evidence-Based Practice does not preclude innovation, but promotes the use of strategies that have already been proven to work. Many Evidence-Based Practices may have begun as innovations that were studied and evaluated to determine their level of effectiveness.

RECOMMENDATIONS

In March 2012, the Metropolitan Social Services Board of Commissioners adopted Policy Recommendations to the Metropolitan Government of Nashville and Davidson County. Detailed information is provided at the link below about the 3 general recommendations and specific recommendations made in 7 different issue areas.

We reiterate the 3 general recommendations that remain relevant for the effective and efficient delivery of services. All 10 policy recommendations include descriptions and examples of how these could be achieved. Briefly, the 3 general policy recommendations were to:

1. Strategically Align Metropolitan Government Resources
2. Enhance Coordination
3. Refine Funding Allocation Process to Nonprofit Organizations

http://www.nashville.gov/portals/0/SiteContent/SocialServices/docs/MSS-PolicyRecommendations-2011CNE.pdf

In addition to the policy recommendations, additional recommendations below were based on information gathered in the development of the 2012 Community Needs Evaluations in the area of Food and Nutrition, Health and Human Development, Housing, Long-Term Supports and Services and Workforce and Economic Opportunity.

ECONOMIC OPPORTUNITY
BEST PRACTICES

Traditional approaches of assisting low-income families focused on providing income supports and social services to people in need. According to CFED, that model has mitigated the pain and hunger of poverty, but often at the cost of undermining the self-esteem, aspirations and work of low-income people. This model focuses on providing opportunities that would lead to sustainable economic advancement by accessing to resources that would help them forward economically.

Expanding Economic Opportunity – Local Assets and Opportunity Profile

The Corporation for Enterprise Development (CFED) is a national nonprofit organization dedicated to expanding economic opportunity for low-income families and communities. They empower low and moderate-income households to build and preserve assets.

In order to help families succeed, CFED developed a *Local Assets and Opportunity Profile,* which is a data tool to help city leaders and local advocates understand and assess the critical problems that perpetuate financial insecurity among their residents. The *Profile* includes a set of over 50 data indicators across seven categories that document and assess the current conditions of financial security, economic opportunity and financial access. This core set of data indicators is designed to provide local leaders with a diagnostic and communications tool in support of their work to improve and expand the financial stability of local residents. The seven categories are:

1. Households in Asset Poverty
2. Population Demographics
3. Household Finances and use of Services
4. Employment and Business Ownership
5. Housing and Homeownership
6. Educational Attainment
7. Health Insurance

CFED works with cities, including Charlotte, Dallas, Minneapolis, Louisville, Seattle, Savannah, Chicago, New York and the other cities that are partners in the Cities for Financial Empowerment Coalition. CFED creates profiles on each city, tracking 50 indicators in the 7 categories listed above. This data is used by the cities to assess current conditions so can work on the issues of financial insecurity and inequality. Community leaders use data to take action to use innovative strategies to increase incomes, savings, assets and financial literacy.

Benefits for Davidson County

The Cities of Financial Empowerment Coalition was founded in 2008 by New York City Mayor Michael Bloomberg and former San Francisco Mayor Gavin Newsom. The member Cities of Financial

Empowerment Coalition work to strengthen the financial health of their cities and of the nation by making access to economic opportunity the model to eradicate poverty in their communities.

CFED notes that there has been some progress in Tennessee, but ranks Tennessee as 42nd, with scores of "C" for Housing & Homeownership and "D" for Financial Assets & Income, Business & Jobs and Education. There is no specific city level ranking for Tennessee, but the poverty rate in Davidson County is even higher than for the state, which suggests an elevated level of asset poverty in Davidson County. Even though the economy in Davidson County has shown recovery in employment, high levels of poverty and asset poverty remain.

Recommendations for Davidson County

Nashville could benefit from participating as one of the Cities for Financial Empowerment. There is little dialogue about the root causes of financial insecurity, although the number of low-income families grows. Most providers of financial assistance struggle to find resources to help those who experience the effects of financial insecurity. Little is being done to address either causation or prevention strategies.

It is becoming apparent that the current systems of support are no longer effective and sustainable. As a result, there are compelling reasons to initiate discussion about the root causes of financial insecurity in the community. Local leadership needs to explore effective strategies that engage government, nonprofit, academic institutions and foundations in order to use a Local Assets and Opportunity Profile. This would provide data and a system of evidence-based decisions to increase the incomes, savings, assets, and financial education opportunities of low-income households.

http://cfed.org/
http://www.cfecoalition.org/
http://cfed.org/policy/local_policy_advocacy/local_profile/

During his address to congress on behalf of people with disabilities, *Michael J. Fox* said that if you ask a person what their favorite therapy is, they will tell you it is the one that works.

Using interventions that work is what evidence-based practice (EBP) is all about. It is not a particularly new concept, as *Dr. David Sackett* originally proposed it for medicine in the early 1990s.

FOOD AND NUTRITION
BEST PRACTICES

Davidson County, several organizations work to combat hunger for vulnerable people, including Second Harvest Food Bank of Middle Tennessee, Community Food Advocates, Bethlehem Centers of Nashville, the Nashville Food Policy Council, Tennessee Department of Human Services and Metropolitan Health Department. Despite these efforts, the lack of food remains a problem for many, particularly because of poverty, unemployment and asset depletion caused by the recession. The effectiveness of these programs could be enhanced by having greater knowledge about the issues of hunger and how to address the unmet basic needs of low-income people.

While there is a national Food Research & Action Center, it focuses on federally funded programs. Many of the food programs use local resources, which could also benefit by additional knowledge and greater coordination how to address food needs.
http://frac.org/

Both the establishment of a Hunger Research Center and enhanced distribution of information can result in better coordination and maximum effectiveness of service delivery through proven research, improved communications and reducing duplication of efforts resulting in improved nutrition for hungry people in Nashville. Some locations have created various types of hunger research organizations, with a variety of models (government, university, private), and examples are below.

Hunger Research Center

North Texas Food Bank – Hunger Research Center
The North Texas Food Bank experienced a rapid increase in the number of persons seeking emergency food assistance partly because of the economic downturn in the economy. In order to address the increasing need with many more working families seeking food assistance, they developed a Hunger Research Center.

The North Texas Food Bank convened a meeting of leaders from the nonprofit, business and academic community to discuss strategies on how to address the issue of local hunger in a systemic way by establishing a Hunger Research Center. The North Texas Food Bank established a collaboration of business leaders, government agencies, and non-profits to conduct research about hunger and its related impact and find solutions to promote healthy food choices in low-income communities to result in effective outcomes.

The Hunger Research Center uses a proactive approach to highlight the causes and effects of hunger on families and communities. It provides a coordinated approach to hunger, nutrition, food insecurity and access to affordable healthy food. Access to affordable, nutritious and healthy food could improve health status in low-income communities, improve student performance in public schools, and increase food security. http://web.ntfb.org/

Benefits to Davidson County
The work of a Hunger Research Center that could focus on local issues, needs and resources would facilitate causes, needs, and resources related to food and hunger. In addition to providers and policy makers, initiatives would include people from the academic and research community to facilitate the process of addressing the root causes of hunger and its long-term consequences. It could also identify ways to most effectively coordinate services and allocate resources.

Nashville has a Food Policy Council (that lacks formality and institutionalization because it was created through a nonbinding resolution) designed to provide input on local policies that effect food availability and access. However, neither the Food Policy Council nor the service providers have systems to coordinate the food programs or to research root causes of hunger so that it could be addressed more effectively.

Recommendations for Davidson County
With the growing need for food assistance and the various efforts to respond to hunger, a lead agency or person could be designated to focus on a broad view of why hunger persist and have the sanction to coordinate sustainable solutions to hunger that create efficiencies and saves money. Various Metropolitan Government departments and various nonprofit organizations are involved in the distribution of food to disadvantaged populations. A Hunger Research Center could serve as hub for the academia, non-profit community and government to identify effective ways to coordinate resources, reduce duplication and develop long-range strategies to address hunger and food access in the region.

Education and Outreach

SHARE Food Program
The Philadelphia Self-Help and Resource Exchange (SHARE) is a local branch of a national umbrella organization. One of their initiatives was to develop a food guide booklet that is distributed through food banks, food stamp offices and non-profits monthly to low income families to help with food purchases and increase access to healthy nutritious foods. Financial incentives and coupons are included in the booklet
http://www.hungercoalition.org/story/fresh-deals
http://sharefoodprogram.org/

HEALTH AND HUMAN DEVELOPMENT
BEST PRACTICES - HEALTH

Tobacco use includes cigarettes, smokeless tobacco, cigars, and pipes, attributable to the deaths of 1 in 5 people. In the U. S., this would be more than 443,000 annually who die prematurely from tobacco use, smoking or exposure to secondhand smoke. Research findings established that smoking rates, tobacco-related illnesses, deaths, and diseases caused by smoking can be reduced through evidence-based programs that consist of comprehensive and coordinated efforts that include educational, clinical, regulatory, funding, and social strategies are necessary for the successful reduction of tobacco use.

REDUCTION OF TOBACCO USE

The Centers for Disease Control's Community Preventive Services Task Force has released evidence based research findings on tobacco use, with interventions for reducing tobacco use. Tobacco use a major cause of premature death and diseases can be prevented through evidence based practices according to the Community Preventive Services Task Force. The Task Force contributes to the development of the Guide to Community Preventive Services, which provides evidence based research findings on public health issues for developing effective community health programs based on best practices. The Centers for Disease Control provides administrative, research and technical support for the Community Preventive Services Task Force.

Benefits for Davidson County

There are numerous ways that residents of Davidson Count could benefit from the reduction in the use of tobacco:

- Improved health outcomes
- Reduction of chronic illnesses secondary to tobacco use
- Reduction of exposure to second hand smoke
- Reduction of tobacco related deaths
- Reduction of medical cost and lost work productivity due to illness

Recommendations for Davidson County

Ongoing educational, clinical, regulatory and funding support are required to successfully implement tobacco reduction strategies. These are sometimes constrained by budgetary issues, politics, lack of public support, or competing interests. However, there are some no-cost or low-cost ways that the Metropolitan Government of Nashville and Davidson County and other organizations could promote the decreased use of tobacco products.

- The Metropolitan Government could be the lead champion for a smoke-free city, with information on the nashville.gov web site. Metro departments could lead the campaign of smoke free campaign and Metro buildings could display of posters, educational literature, smoking cessation services, and multiple media campaigns to prevent or reduce tobacco use.
- Free series of classes to quit smoking, along with support groups offered to employees and the public, coordinated through the Metro Health Department in conjunction with nonprofit health-related organizations. Certificates of completion could be used by individuals for possible health premium discounts through their health insurance.
- Promote free classes on the dangers of smoking plus support to quit smoking should be discussed and offered for pregnant mothers and parents with toddlers at all public health departments in the county.
- All Metro schools should provide more intense campaigns to prevent the start of smoking with students starting from elementary to high schools students, as well as faculty, staff and administrators.
- Engage Faith Based and Non Profit groups in education and campaigns for smoke free environments and offer free assistance for those groups assistance to get started.

HEALTH AND HUMAN SERVICES
BEST PRACTICES – CHILDHOOD DEVELOPMENT

Research has shown that distributing reading material for children to their parents or guardians has a significant effect on the behavior of the parent/guardian by increasing the likelihood of reading to the children. In particular, there are studies showing that parents who receive books and literacy counseling from their pediatricians are more likely to read to their young children and bring more books into the home.

REACH OUT AND READ

Reach Out and Read (ROR) is an evidence-based model developed in 1989 at the Boston Medical Center that prepares preschool children to succeed in school by collaborating with medical primary care providers to prescribe books and encourage children and families to read. The Reach Out and Read program was developed through a formal collaboration of pediatricians and educators, and it is an evidenced-based model that promotes early childhood reading for vocabulary development, language skills and preparation for future academic success of America's children. The Reach Out and Read model is endorsed by the American Academy of Pediatrics, and the program has a compelling record of research support as an effective component in primary care intervention for young children.

The Reach Out and Read program prepares children ages 6 months to 5 years to succeed in school through pediatricians, nurse practitioners, and other medical primary care providers who prescribe books and advise parents on the importance of reading to their children. The medical primary care

providers incorporate into each of the child's regular pediatric checkups (also known as well-child checkups) advice to the parent or guardian on the importance of reading. The parent or guardian is given a new book for their child based on the child's age and development at each well child visit. The choices of books provided are age appropriate, and in multiple languages according to the providers patient base and language availability of books.

Nationally there are nearly 4,900 medical offices in 50 U.S. states within hospitals and health care centers that already participate in the ROR program. Annually 6.5 million books to children and literacy advice to parents are distributed nationally through ROR. In Tennessee, there are 10 ROR program medical sites, with about 13,000 children served annually, and approximately 18,000 books annually distributed.
http://reachoutandread.org/about-us/

Benefits for Davidson County
Davidson County has a successful ROR program at Vanderbilt University in the Division of General Pediatrics. Approximately 3,000 books are given away to children annually at the pediatric clinics. The program was founded in 2000 at the Monroe Carell, Jr. Children's Hospital at Vanderbilt, so there is evidence to support possible replication through other pediatric care providers in Davidson County.

For several years, there has been a highly-respected early childhood literacy program operated by the Governor's Books from Birth Foundation in an innovative partnership with Dolly Parton's Imagination Library. Davidson County's program was established in May 2005 and estimates that 47% of children under age 5 receive Imagination Library Books. It has distributed an impressive volume of 1,231,087 books since the program began.

Books from Birth has been extremely successful but does not reach 100% of children. In addition, it does not use the emerging practice of distribution through pediatric services. As efforts are made to increase distribution to a larger percentage of children, either through local pediatric practitioners in partnership with sponsors or other expanded funding sources, books could be distributed through pediatric health care providers. This would also allow a comparison of the outcomes of each distribution system.

Recommendations
Early childhood development has been well-established in increasing the high school graduation rate. Public-private partnerships could be developed to increase awareness and support of ROR in Nashville, backed by the extensive evidence-based research that could inspire additional programs, including those with a pediatric health provider distribution model. As with the Books to Birth Program, funding partnerships could be explored from corporations and private foundations to support the academic and future development of young children.

The national office of the Reach Out and Reach program is available to provide technical support, training and promotion for program development of interested parties. The Nashville Health Care Council could promote support for Reach Out and Read to Nashville's health care centers and primary care providers of pediatric services. There may also be opportunities for collaborations with local universities for volunteers and student internships, organized volunteer organizations or others.

HOUSING
BEST PRACTICES

Housing Trust Funds

Housing Trust Funds are specific funds established by government entities (local, regional or state) to produce and preserve affordable housing.

This type of fund was first created in the mid-1970s with dedicated public funding sources and private sources. The National Association of Realtors has estimated that there are over 650 housing trust funds in cities, counties and states that generate over $1 billion a year to address housing needs. HTFs most often use new revenue, such as a new tax or fee, which does not take away funding from other programs. Additional background information about housing trust funds and best practices may be found in the 2011 Community Needs Evaluation.

Housing Trust Funds can address the shortage of affordable housing in several ways. First, they are more flexible than direct federal and state government funding, which often has additional restrictions. HTF advisory boards can set policies (eligibility, use of funds, etc.) that can be changed as local conditions change. HTFs can be used to encourage collaborations among housing developers, including both the non-profit and private sectors. Local housing trust funds can also raise general community awareness of the unmet housing need among business, foundations and other potential fund contributors. It is well-documented that HTFs also contribute to the local economy, revitalization of neighborhoods and reduction of poverty, which can have effects on children's school performance and contribute to other positive outcomes.

Benefits to Davidson County

A Housing Trust Fund could help address the significant numbers of Davidson County homeowners and renters who are cost-burdened. These households each pay more than 30% of their income for housing and related expenses. The 2011 American Community Survey estimates that 38,890 Davidson County homeowners and 58,170 renters are cost burdened.

There is a major challenge with identifying ongoing funding and that policy makers understanding the lasting and long-reaching problems caused by the lack of affordable housing, so they would commit to a funding strategy. Funding has been addressed in different ways by other locations. The best models use stable recurring government funding to operate and to leverage money from other sources. Many HTFs have started with a modest amount of local government funding (e.g. $4-$7 million) and built upon that recurring source by soliciting participation from business and foundations as the HTF's positive effects are shown.

Recommendation for Davidson County

In 2008, the Metropolitan Council approved a resolution asking the Metropolitan Planning Department "to develop a plan for the equitable distribution of affordable housing throughout Metropolitan Nashville and Davidson County." In response, the Metropolitan Planning Department produced a

report in 2009 that described the lack of affordable housing's detrimental effects on jobs, the environment, and the local economy. It also identified policies and practices that could increase the development of lower cost housing.

In 2011, a group of Vanderbilt University students in the Cal Turner Program for Moral Leadership in the Professions took on the task of addressing the continuing need to establish a Housing Trust Fund in Davidson County. They did preliminary research and assembled a group of interested parties, including people from government, non-profit and for-profit sectors. This group adopted the name Barnes Affordable Housing Trust Fund Coalition to honor Rev. Bill Barnes, a long-time advocate for housing diversity and elimination of pockets of concentrated poverty.

The Barnes Affordable Housing Trust Fund Coalition focuses on developing a sustainable, predictable pool of funds to be used for affordable housing in Davidson County. After funds are identified, they would be used for competitive awards to organizations for them to develop housing opportunities for very low to moderate-income families and individuals. The housing would especially target households with very low income (earning less than 50% of area median income) and/or where unmet needs are critical.

By December 2012, the Coalition had formalized a preliminary plan with enough specificity to begin exploring community support. The Coalition may be contacted at barneshousingcoalition@gmail.com

Housing Trust Fund information:
http://housingtrustfundproject.org/
http://www.policylink.org/site/c.lkIXLbMNJrE/b.5137005/k.DB1/Housing_Trust_Funds.htm
http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing/programs/home/htf

LONG-TERM SERVICES AND SUPPORTS
BEST PRACTICES

As the population continues to age, the need for trained caregivers will increase. There are organizations that assist caregivers in the form of information, referrals and various types of support. However, there is also a need for direct training for caregivers who provide hands-on home care for the frail elderly.

Direct Care Training for Caregivers

Most in-home services are provided by paid individuals and/or organizations. These paid providers have usually received specialized training on how to safely assist the frail elderly. There are many frail elderly persons who receive care from unpaid family caregivers, who usually have received little or no training on how to safely and effectively provide hands-on assistance to frail elderly persons. Due to

lack of training, the caregiver and the person who is being cared for are at risk for accidental injury or harm through lack of skills.

With the continuing increase in the aging population, there is a need for hands-on training for family members to facilitate direct care. As the number of frail elderly persons who have limited training and resources to provide one-on-one hands on direct care, there is a growing need to provide training and support for family caregivers.

One-on-one, hands-on direct care trainings would include training on how to safely and effectively assist frail elderly family members, such as:

- Make living environments safer
- Bed to chair transfer
- Chair to bathroom transfer
- Chair to car transfer
- Improve mobility functions for frail elderly
- Support bathing and grooming activities

American Association of Retired Persons, Tennessee Commission on Aging and Disability, Greater Nashville Regional Council provide general caregiver training, but does not teach hands-on family caregiver training. There are training programs to assist caregivers with emotional support, respite care, information and referrals. While these are valuable resources, they do not address the physical demands sometimes required in the care of frail elderly persons. With the aging population, there will be an increasing need for hands-on caregiver training for persons who want to care for their family members at home to insure safety for both the caregiver and their family members.
The Tennessee Commission on Aging and Disability, through the National Family Caregiver Support Program, provides information statewide for caregivers of available services, counseling, support groups, respite care and referrals to other agencies.
http://www.tn.gov/comaging/caregiving.html

The Greater Nashville Regional Council Family Caregiver Services program provides support groups, counseling, training and supplemental services in the Middle Tennessee area.
https://www.gnrc.org/agencies-programs/aaad/about-aaad/family-caregiver/

Benefits to Davidson County
Direct care training for family caregivers could assist in keeping persons in their homes and avoid more costly institutional care. Training in the areas of bed to chair transfer, chair to bathroom transfer, making living environments safer, improve mobility functions for frail elderly persons and support for bathing and grooming activities could prevent accidental injuries and be beneficial to both the caregiver and the care recipient.

Caregivers would be expected to attend trainings that would cover topics such as CPR, First Aid, Fire Safety and Evacuation, Abuse Prevention, Protection from Harm and Universal Precaution method, as

well as hands-on training specific to the needs of the person. Trainings would be conducted by persons with knowledge of specific subject areas from various Metropolitan Government departments, universities, hospital, and agencies working with persons with a disability and seniors.

Recommendations for Davidson County

There are various ways to create a system of training, by incorporating existing resources. With coordination and limited support from local government, trainings could be provided for unpaid family caregivers using existing training models

The Metropolitan Government of Nashville and Davidson County is one of the few jurisdictions that operates an Assisted Living Facility (Knowles Home) and a Long-Term Care nursing facility (Bordeaux Hospital), both part of the Metropolitan Hospital Authority. There are also for-profit and non-profit community based agencies working to provide LTSS for the elderly and disabled. There are numerous people throughout these organizations who would be qualified to provide the training (staff from the Metropolitan Hospital Authority, physical and occupational therapists, schools of nursing from local universities and other trained professionals.

Such a model could be done in collaboration with organizations that have experience in providing various types of training to benefit the frail elderly and disabled. For example, the Council on Aging of Greater Nashville previously provided door-through-door transportation training for relative caregivers in past years. Scheduling and securing space for family caregiver training could be organized through existing agencies serving adults with disabilities, with trainings would be provided by volunteer professionals with experience in assisting frail elderly individuals.

WORKFORCE DEVELOPMENT
BEST PRACTICES

The process of searching employment, especially during recessions, is intimidating when the prospects are diminishing. Long-term unemployment takes a toll on self-esteem of the individual. Job seekers get frustrated and lose momentum because it may take a considerable time to find a job. During the process, they may lose confidence, question their skills and doubt their ability. Their job search ability could benefit from support and assistance needed to secure employment, in addition to specific services they may receive from an employment services agency.

A Job Club can promote success in securing employment through regular meetings, assigned tasks and assessment of progress. This ongoing intervention helps job seekers keep momentum and focus on what is needed to result in a successful job search.

Job Clubs

There are various models of job clubs that provide job seekers with the opportunity to network with others seeking employment in a particular location. Job clubs help job seekers meet their peers, share experiences, challenges and successes with the goal of supporting the success of all members. For some years, faith organizations have informally provided their members and communities with informal opportunities that led to programs and facilitated discussions about unemployment and networking. This type of discussion and networking can increase the opportunity for participants to secure employment.

In order to strengthen those informal settings, the U.S. Department of Labor's Center for Faith-based and Neighborhood Partnerships (CFBNP) created the Job Club Initiative in May 2011. The goal is to create faith and community based job clubs, facilitate networking between job clubs and increase awareness of the role they play in assisting people to return to work.
http://www.dol.gov/cfbnp/20110524.htm
https://partnerships.workforce3one.org/

The creation of job clubs would require not only leadership but also resources and other commitments from supporters of such an initiative. Participation could expand by community awareness and through recruitment by other unemployed or underemployed participants.

Benefits to Davidson County

Support and assistance from a job club could shorten the sometimes-lengthy path to employment. In Williamson County, the Brentwood United Methodist Church has hosted something similar to a job club for 21 years, although it is called the Career Transition Support Group. That particular congregation has sufficient resources so that there is no cost to participants. Most unemployed and underemployed low-income people may not have the time to organize, find a location free of charge and recruit participants who bring the various industry backgrounds that can expand the opportunity to land jobs.

Davidson County has the potential to create job clubs that can assist unemployed workers in the community. The existence of strengthened relationship among many public and private entities that assist low-income job seekers is already an asset, which can be a foundation to form new job clubs. Two challenges exist, location for the meetings and volunteers to coordinate the job clubs, and these could be addressed through the established infrastructure of the various faith and community based organizations. This would facilitate the development of local job clubs to assist those who need jobs to support themselves and their families.

The Workforce Team of the Nashville Poverty Reduction Initiative has already organized a number of workshops to promote job opportunities for vulnerable groups, such as mature workers, immigrants and refugees, people with disabilities, and veterans. There is the potential for including the organization of job clubs among the group's activities.

For Additional Information

The annual Community Needs Evaluation is provided as a service to the community and is a tool that can provide current data with an array of information on trends, gaps in services and best practices. The information is provided to enhance informed decisions by Davidson County's policy makers, philanthropists, service providers and others.

The Community Needs Evaluation is expected to continue as an annual publication. However, the document should not be the sole source of information for several reasons. While a broad range of issues are included in the Community Needs Evaluations, space and time limitations do not permit analysis of the entire range of social/human service needs. In addition, new information becomes available more frequently than on an annual basis. Because of the importance of having a wide range of current information available on a regular basis, Metropolitan Social Services-Planning & Coordination also provides:

- Quarterly newsletters with brief relevant information about a wide range of issues, trends and other information about people in need. These include emerging issues, recent research
- *Issues of Interest – Information You Can* are released regularly to provide analysis in greater depth on specific areas.
- Data Reports, including those that compare census tracts or Metropolitan Council Districts.
- Because sources of information are presented in summary form, links to original sources are provided within these documents, so that additional information is readily available for readers.

The information described above and additional information is available online through the Metropolitan Social Services web site: http://www.nashville.gov/Social-Services.aspx

U. S. Census/American Community Survey Data
http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Interactive Maps:
http://www.census.gov/geo/maps-data/
http://www.richblockspoorblocks.com/
http://projects.nytimes.com/census/2010/map

For additional information, please contact the Planning & Coordination staff by email at MSSPC@nashville.gov or by telephone:

- Dinah Gregory, Planning & Coordination Director – 615-862-6494
- Abdelghani Barre, Planning Analyst – Workforce & Economic Opportunity – 615-862-6459
- Lee Stewart, Planning Analyst – Housing & Related Assistance (including Neighborhoods) – 615-862-6975
- Julius Witherspoon, Planning Analyst – Food & Nutrition; Long-Term Supportive Services – 615-880-2532
- Joyce Hillman, Planning Analyst – Health & Human Development (including Child Care) – 615-862-6439

Community Needs Survey – Davidson County, Tennessee

YOUR OPINION IS IMPORTANT TO US

Metropolitan Social Services wants to know what you think are the greatest social service needs in Nashville. We're asking a lot of people in Nashville to take this survey, and the results will be used for evaluating and planning social services for Davidson County, and will be shared with community leaders and on our web site. **All answers are confidential, so please do not write your name on the survey.** Choose one answer for each question and fill in the circle next to your answer. Thank you!

Please fill in circles like this: ● NOT with an **X** or a ✓

1. Please indicate the ZIP CODE where you live: _____

2. Please mark Nashville's greatest need in FOOD & NUTRITION.

- ○ Food Boxes/Food Pantries
- ○ Food for Elderly or Disabled Persons
- ○ Food for Infants and Young Children
- ○ Food for School Children
- ○ Food Stamps
- ○ Other (please specify) _____

3. Please mark Nashville's greatest need in HOUSING & RELATED ASSISTANCE.

- ○ Emergency Shelter
- ○ Help Paying Mortgage Payments
- ○ Help Paying Utility Bills
- ○ Help with Rent Payments
- ○ Homeowner Education and Training
- ○ Public Housing Units
- ○ Section 8 Vouchers
- ○ Other (please specify) _____

4. Please mark Nashville's greatest need in HEALTH.

- ○ Preventive Care
- ○ Basic Health Care for Uninsured and Underserved
- ○ Specialty Care (dental, vision, etc.)
- ○ Mental Health Care or Substance Abuse Treatment
- ○ Other (please specify) _____

Please turn this page over. A few more questions are on the back. THANK YOU.

5. Please mark Nashville's greatest need in WORKFORCE & ECONOMIC OPPORTUNITY.

- ☐ College or Junior College
- ☐ GED Assistance, Adult Education
- ☐ Help Finding a Job/Job Placement
- ☐ Job Training
- ☐ Life Skills Counseling, Case Management
- ☐ Public Benefits, including SSI, SSA, TANF, etc.
- ☐ Training About Money and Finances
- ☐ Vocational Training
- ☐ Other (please specify) _____

6. Please mark Nashville's greatest need in HOME & COMMUNITY BASED SERVICES.

- ☐ Child Care Closer to My Home
- ☐ Help Paying for Child Care
- ☐ Homemaker Services for Elderly or Disabled People
- ☐ Homemaker Services for Relative Caregivers (raising the children of relatives)
- ☐ More Infant Child Care
- ☐ Other (please specify) _____

7. Please mark Nashville's greatest need in NEIGHBORHOOD DEVELOPMENT.

- ☐ Crime Prevention/Public Safety
- ☐ Diverse Housing Options
- ☐ Access to Public Transportation
- ☐ Active Neighborhood Associations
- ☐ Other (please specify) _____

8. Which social/human service need has the largest gap between the services now available and what is needed?

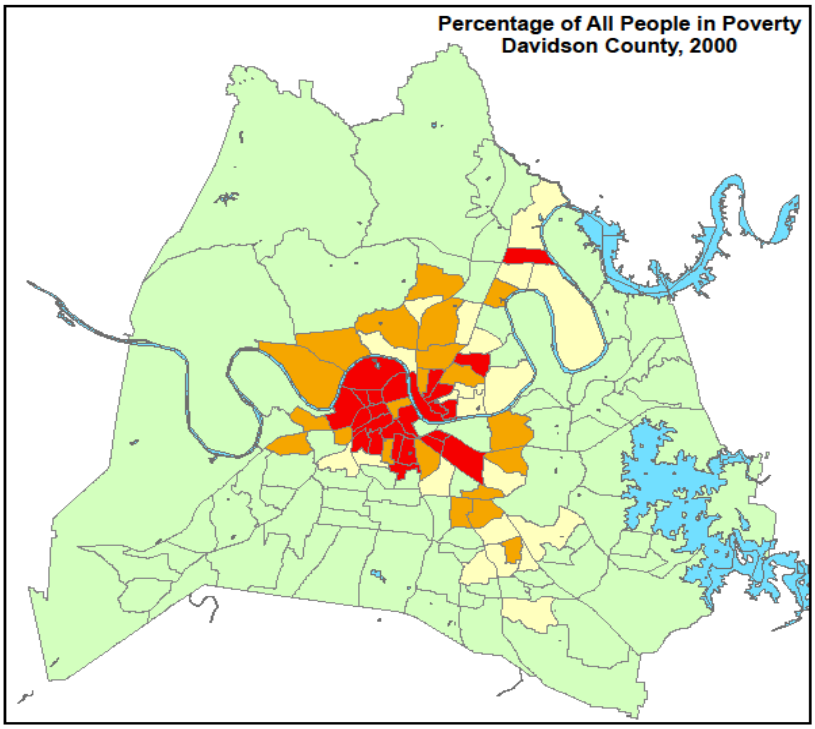
- ☐ Food & Nutrition
- ☐ Health
- ☐ Home & Community Based Services for Adults/Seniors
- ☐ Child Care
- ☐ Housing & Related Assistance
- ☐ Neighborhood Development
- ☐ Transportation
- ☐ Workforce & Economic Development
- ☐ Other (please specify) _____

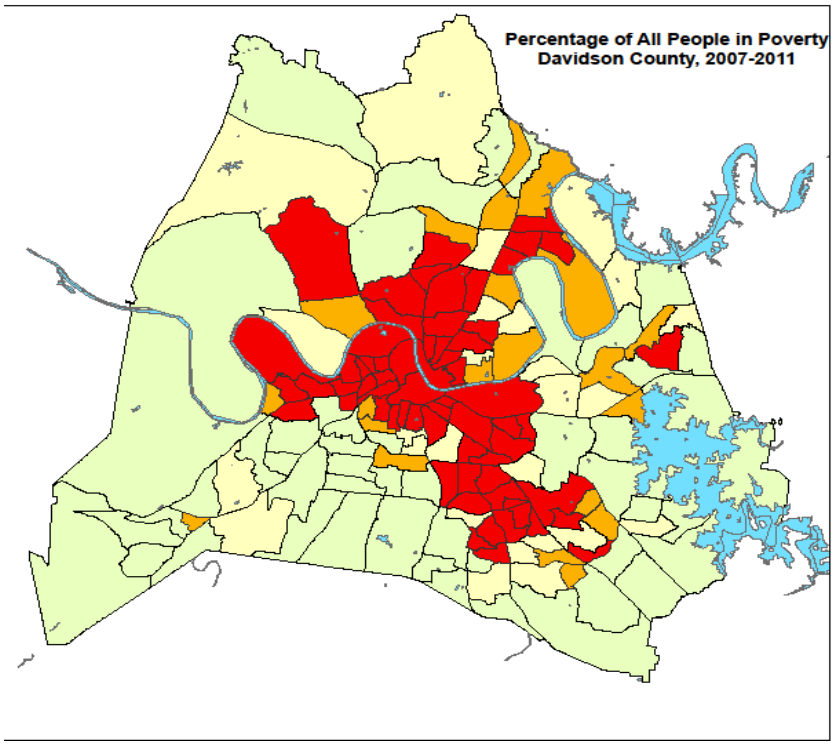
Other Comments?

Comparison of Poverty in Davidson County

U. S. Census Bureau Data – Shapefiles by Metropolitan Planning Department – Maps by Metro Social Services

2000 Decennial Census and American Community Survey Estimates 2007-2011





SCHOOL ENROLLMENT and EDUCATIONAL ATTAINMENT	United States					Tennessee					Davidson County, Tennessee				
	2011	2010	2009	2008	2007	2011	2010	2009	2008	2007	2011	2010	2009	2008	2007
SCHOOL ENROLLMENT															
Population 3 years and over enrolled in school	83,131,910	82,724,222	81,173,053	79,845,430	79,329,527	1,594,654	1,598,191	1,545,457	1,527,939	1,487,774	159,043	158,649	155,959	160,842	156,319
Nursery school, preschool	6.0%	6.0%	6.3%	6.4%	6.2%	5.6%	5.4%	5.6%	6.0%	5.4%	6.1%	5.9%	7.5%	7.0%	5.0%
Kindergarten	5.1%	5.1%	5.1%	5.1%	5.1%	4.7%	5.0%	5.5%	5.5%	5.7%	4.9%	4.7%	6.0%	5.5%	5.5%
Elementary school (grades 1-8)	39.5%	39.8%	40.0%	40.3%	40.5%	42.6%	41.9%	41.9%	42.6%	42.9%	37.2%	36.2%	35.7%	40.2%	40.1%
High school (grades 9-12)	20.7%	20.8%	21.1%	21.6%	22.0%	20.9%	21.5%	22.2%	21.9%	22.9%	16.2%	16.9%	17.6%	18.0%	19.1%
College or graduate school	28.7%	28.3%	27.4%	26.7%	26.2%	26.1%	26.3%	24.7%	24.0%	23.1%	35.5%	36.4%	33.2%	29.2%	30.3%
EDUCATIONAL ATTAINMENT															
Population 25 years and over	206,471,670	204,288,933	201,952,383	200,029,554	197,892,369	4,294,392	4,242,391	4,213,368	4,178,311	4,122,693	425,472	418,090	429,102	420,422	415,874
Less than 9th grade	6.0%	6.1%	6.3%	6.4%	6.4%	6.1%	6.2%	6.5%	6.6%	7.1%	4.7%	5.0%	5.3%	5.1%	5.6%
9th to 12th grade, no diploma	8.1%	8.3%	8.5%	8.7%	9.1%	9.7%	10.1%	10.4%	10.4%	11.5%	9.1%	10.7%	8.4%	10.3%	9.6%
High school graduate (includes equivalency)	28.4%	28.5%	28.5%	28.5%	30.1%	33.4%	33.5%	33.0%	32.5%	34.3%	25.6%	24.4%	24.0%	25.8%	26.0%
Some college, no degree	21.2%	21.3%	21.3%	21.3%	19.5%	21.2%	20.8%	21.1%	21.6%	19.6%	21.1%	19.5%	20.9%	21.1%	19.5%
Associate's degree	7.8%	7.6%	7.5%	7.5%	7.4%	6.0%	6.2%	6.1%	6.0%	5.7%	4.9%	6.0%	6.2%	5.6%	5.8%
Bachelor's degree	17.9%	17.7%	17.6%	17.5%	17.4%	15.3%	14.6%	15.1%	14.8%	14.2%	22.4%	20.6%	22.8%	19.9%	22.1%
Graduate or professional degree	10.6%	10.4%	10.3%	10.2%	10.1%	8.3%	8.5%	7.9%	8.0%	7.6%	12.2%	13.9%	12.4%	12.1%	11.3%
Percent high school graduate or higher	85.9%	85.6%	85.3%	84.9%	84.5%	84.2%	83.6%	83.1%	83.0%	81.4%	86.2%	84.3%	86.4%	84.5%	84.7%
Percent bachelor's degree or higher	28.5%	28.2%	27.9%	27.7%	27.5%	23.6%	23.1%	23.0%	22.8%	21.8%	34.6%	34.5%	35.2%	32.0%	33.4%

HOUSEHOLDS and RELATIONSHIP	United States					Tennessee					Davidson County, Tennessee				
	2011	2010	2009	2008	2007	2011	2010	2009	2008	2007	2011	2010	2009	2008	2007
TOTAL HOUSEHOLDS	114,991,725	114,567,419	113,616,229	113,097,835	112,377,977	2,467,428	2,440,663	2,447,066	2,434,398	2,407,765	254,655	249,899	255,290	257,182	250,958
Family households (families)	66.2%	66.4%	66.5%	66.6%	66.8%	65.9%	67.4%	67.0%	66.9%	66.7%	54.3%	56.6%	56.1%	55.3%	55.0%
With own children under 18 years	29.4%	29.7%	30.3%	30.8%	31.1%	27.3%	28.0%	29.1%	29.4%	29.2%	23.7%	24.3%	25.3%	24.9%	24.4%
Married-couple family	48.3%	48.6%	49.1%	49.4%	49.7%	48.2%	49.0%	49.3%	49.8%	49.2%	36.6%	36.1%	37.6%	37.3%	37.3%
With own children under 18 years	19.6%	20.0%	20.6%	21.2%	21.4%	18.1%	18.2%	19.3%	19.7%	19.1%	14.2%	13.2%	14.8%	15.1%	14.4%
Male householder, no wife present, family	4.7%	4.7%	4.6%	4.6%	4.6%	4.4%	4.4%	4.4%	4.1%	4.5%	3.7%	4.9%	3.7%	4.4%	3.9%
With own children under 18 years	2.3%	2.3%	2.3%	2.3%	2.3%	1.9%	2.0%	2.3%	2.1%	2.3%	1.8%	2.1%	1.6%	1.9%	1.6%
Female householder, no husband present, family	13.1%	13.1%	12.7%	12.6%	12.5%	13.3%	14.0%	13.3%	13.0%	12.9%	14.1%	15.6%	14.8%	13.6%	13.7%
With own children under 18 years	7.4%	7.4%	7.4%	7.4%	7.4%	7.3%	7.8%	7.5%	7.5%	7.8%	7.6%	9.0%	9.0%	7.9%	8.4%
Nonfamily households	33.8%	33.6%	33.5%	33.4%	33.2%	34.1%	32.6%	33.0%	33.1%	33.3%	45.7%	43.4%	43.9%	44.7%	45.0%
Householder living alone	27.7%	27.4%	27.5%	27.5%	27.3%	29.0%	27.7%	28.0%	28.2%	28.1%	37.5%	34.5%	35.7%	37.0%	37.8%
65 years and over	9.7%	9.5%	9.4%	9.3%	9.1%	9.6%	9.4%	9.2%	9.2%	9.2%	8.2%	8.0%	8.0%	9.2%	8.4%
Households with one or more people under 18 years	32.7%	33.1%	33.5%	34.0%	34.4%	31.1%	31.9%	33.1%	33.1%	32.8%	26.8%	28.0%	28.1%	27.6%	27.1%
Households with one or more people 65 years and over	25.2%	24.8%	24.2%	23.8%	23.4%	25.2%	25.0%	24.1%	23.7%	23.0%	18.8%	19.3%	19.3%	19.7%	18.7%
Average household size	2.64	2.63	2.63	2.62	2.61	2.53	2.54	2.51	2.49	2.49	2.4	2.41	2.41	2.35	2.38
Average family size	3.25	3.23	3.23	3.21	3.2	3.13	3.1	3.07	3.06	3.05	3.23	3.14	3.17	3.17	3.2
RELATIONSHIP															
Population in households	303,585,583	301,362,366	298,729,438	295,812,889	293,499,975	6,249,881	6,203,425	6,145,155	6,062,405	6,004,332	611,244	602,336	615,255	603,710	596,461
Householder	37.9%	38.0%	38.0%	38.2%	38.3%	39.5%	39.3%	39.8%	40.2%	40.1%	41.7%	41.5%	41.5%	42.6%	42.1%
Spouse	18.3%	18.5%	18.7%	18.9%	19.0%	19.0%	19.3%	19.6%	20.0%	19.7%	15.3%	15.0%	15.6%	15.8%	15.7%
Child	30.8%	30.6%	30.8%	30.7%	30.5%	29.5%	29.6%	29.3%	29.2%	28.9%	27.9%	27.8%	28.6%	28.1%	27.9%
Other relatives	7.3%	7.2%	6.9%	6.8%	6.7%	7.0%	6.8%	6.4%	6.2%	6.2%	7.3%	7.6%	6.4%	7.3%	7.3%
Nonrelatives	5.8%	5.8%	5.6%	5.4%	5.5%	5.0%	4.9%	4.9%	4.5%	5.0%	7.9%	8.1%	7.9%	6.2%	7.1%
Unmarried partner	2.2%	2.3%	2.2%	2.1%	2.1%	1.9%	2.0%	2.1%	1.9%	2.0%	2.4%	3.1%	2.6%	2.0%	2.2%

	United States					Tennessee					Davidson County, Tennessee				
Income	2011	2010	2009	2008	2007	2011	2010	2009	2008	2007	2011	2010	2009	2008	2007
Per capita income	$26,708	$26,881	$27,692	$28,749	$28,949	$23,320	$23,171	$23,802	$25,154	$25,402	$27,480	$26,812	$28,435	$30,185	$30,318
Median nonfamily income	$30,500	$31,077	$31,850	$32,684	$33,494	$25,243	$24,907	$26,144	$26,873	$27,757	$33,549	$32,921	$37,466	$35,717	$36,664
Mean nonfamily income	$44,404	$44,840	$45,989	$47,351	$47,796	$36,197	$34,865	$37,106	$37,555	$38,050	$47,077	$43,539	$50,120	$50,070	$48,746
Median earnings for workers	$29,538	$29,647	$30,022	$30,506	$31,050	$26,281	$26,414	$26,793	$26,963	$27,514	$26,898	$26,531	$29,082	$30,559	$31,308
Median earnings for male full-time, year-round workers	$46,993	$47,199	$47,104	$47,173	$47,626	$41,309	$42,017	$41,081	$41,601	$42,234	$40,562	$41,594	$41,034	$42,525	$43,305
Median earnings for female full-time, year-round workers	$37,133	$37,200	$37,238	$36,551	$37,154	$33,184	$32,702	$32,461	$31,788	$32,705	$36,276	$37,267	$38,064	$35,830	$35,379

	United States					Tennessee					Davidson County, Tennessee				
PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL	2011 Estimate	2010 Estimate	2009 Estimate	2008 Estimate	2007 Estimate	2011 Estimate	2010 Estimate	2009 Estimate	2008 Estimate	2007 Estimate	2011 Estimate	2010 Estimate	2009 Estimate	2008 Estimate	2007 Estimate
All families	11.7%	11.3%	10.5%	9.8%	9.5%	13.7%	13.4%	13.1%	11.8%	12.0%	14.6%	15.7%	12.3%	12.5%	10.4%
With related children under 18 years	18.6%	17.9%	16.6%	15.2%	14.9%	22.4%	21.5%	20.3%	18.4%	18.9%	25.3%	26.3%	21.0%	20.4%	17.8%
With related children under 5 years only	19.4%	19.3%	17.9%	16.5%	16.0%	24.4%	25.0%	25.0%	21.4%	21.9%	25.9%	25.2%	24.1%	19.5%	23.2%
Married couple families	5.8%	5.6%	5.1%	4.7%	4.5%	6.9%	6.8%	6.5%	5.6%	5.6%	6.1%	6.4%	6.0%	6.1%	4.6%
With related children under 18 years	8.8%	8.4%	7.5%	6.6%	6.4%	10.8%	10.4%	9.0%	7.5%	7.7%	11.6%	10.5%	10.5%	10.0%	8.4%
With related children under 5 years only	7.4%	7.6%	6.9%	6.0%	5.9%	8.9%	11.3%	11.0%	7.4%	7.1%	10.7%	8.2%	14.3%	8.9%	12.6%
Families with female householder, no husband present	31.4%	30.3%	29.4%	28.1%	28.2%	35.6%	34.0%	35.0%	33.1%	34.3%	34.3%	36.0%	28.6%	28.2%	26.7%
With related children under 18 years	40.8%	39.6%	38.2%	36.5%	36.5%	46.1%	43.8%	44.2%	42.5%	43.3%	45.2%	47.8%	38.1%	38.7%	34.4%
With related children under 5 years only	47.9%	47.7%	45.6%	45.3%	44.8%	56.0%	51.9%	57.1%	54.9%	54.1%	49.0%	56.6%	53.9%	45.5%	49.0%
All people	15.9%	15.3%	14.3%	13.3%	13.0%	18.3%	17.7%	17.1%	15.7%	15.9%	19.3%	20.2%	16.9%	16.9%	14.9%
Under 18 years	22.5%	21.6%	20.0%	18.3%	18.0%	26.3%	25.7%	23.9%	22.0%	23.0%	30.5%	32.2%	27.3%	26.7%	24.7%
Related children under 18 years	22.2%	21.2%	19.7%	18.0%	17.6%	26.0%	25.3%	23.5%	21.7%	22.5%	30.3%	31.9%	27.1%	26.6%	24.7%
Related children under 5 years	25.8%	25.0%	23.2%	21.4%	20.8%	30.8%	29.6%	29.4%	26.8%	28.5%	33.2%	34.9%	34.3%	29.1%	34.6%
Related children 5 to 17 years	20.8%	19.8%	18.2%	16.6%	16.4%	24.2%	23.7%	21.1%	19.7%	20.2%	28.9%	30.4%	23.4%	25.5%	20.2%
18 years and over	13.9%	13.3%	12.5%	11.6%	11.3%	15.8%	15.2%	15.0%	13.7%	13.7%	16.0%	16.7%	13.9%	13.7%	11.8%
18 to 64 years	14.8%	14.2%	13.1%	12.0%	11.6%	16.9%	16.4%	15.8%	14.1%	14.0%	17.3%	17.7%	14.8%	14.0%	12.1%
65 years and over	9.3%	9.0%	9.5%	9.9%	9.5%	10.7%	9.7%	11.1%	11.6%	12.0%	8.0%	10.8%	8.1%	11.9%	10.0%
People in families	13.4%	12.8%	11.8%	10.8%	10.6%	15.7%	15.1%	14.5%	13.1%	13.3%	17.2%	18.0%	15.5%	15.5%	13.2%
Unrelated individuals 15 years and over	27.0%	26.2%	25.4%	24.3%	23.6%	29.6%	29.5%	29.2%	27.8%	27.4%	24.9%	26.3%	20.7%	21.1%	19.8%

	United States		Tennessee		Davidson County	
Median Income by Race, Age, Family Status	**Total**	**Median income (dollars)**	**Total**	**Median income (dollars)**	**Total**	**Median income (dollars)**
Households	114,991,725	$ 50,502	2,467,428	$ 41,693	254,655	$ 43,556
One race--						
White	78.0%	$ 53,444	80.5%	$ 44,689	66.1%	$ 50,779
Black or African American	12.1%	$ 33,223	15.8%	$ 29,352	26.6%	$ 29,674
American Indian and Alaska Native	0.7%	$ 35,192	0.3%	$ 40,569	-	$ 61,957
Asian	4.0%	$ 67,885	1.1%	$ 66,696	2.2%	$ 56,265
Native Hawaiian and Other Pacific Islander	0.1%	$ 49,378	-	$ 79,147	-	$ 41,631
Some other race	3.3%	$ 37,172	1.1%	$ 29,899	3.4%	$ 25,718
Two or more races	1.7%	$ 44,115	1.2%	$ 33,125	1.5%	$ 34,152
Hispanic or Latino origin (of any race)	11.9%	$ 39,589	2.9%	$ 32,015	6.1%	$ 33,534
White alone, not Hispanic or Latino	70.2%	$ 55,305	78.8%	$ 45,058	63.6%	$ 50,917
HOUSEHOLD INCOME BY AGE OF HOUSEHOLDER						
15 to 24 years	4.1%	$ 23,788	4.4%	$ 21,514	5.7%	$ 20,838
25 to 44 years	33.7%	$ 54,768	33.3%	$ 45,722	41.7%	$ 44,742
45 to 64 years	40.1%	$ 61,148	40.0%	$ 50,350	35.9%	$ 52,690
65 years and over	22.1%	$ 35,107	22.3%	$ 30,186	16.7%	$ 35,835
FAMILIES						
Families	76,084,006	$ 61,455	1,625,686	$ 52,273	138,392	$ 54,520
With own children under 18 years	44.4%	$ 58,035	41.5%	$ 49,417	43.6%	$ 44,108
With no own children under 18 years	55.6%	$ 63,701	58.5%	$ 54,317	56.4%	$ 62,565
Married-couple families	73.0%	$ 74,392	73.2%	$ 62,738	67.3%	$ 70,560
Female householder, no husband present	19.9%	$ 30,052	20.2%	$ 25,582	25.9%	$ 26,317
Male householder, no wife present	7.2%	$ 41,763	6.6%	$ 35,114	6.8%	$ 32,406
NONFAMILY HOUSEHOLDS						
Nonfamily households	38,907,719	$ 30,500	841,742	$ 25,243	116,263	$ 33,549
Female householder	53.7%	$ 26,288	54.20%	$ 23,002	52.8%	$ 31,830
Living alone	45.7%	$ 23,631	47.20%	$ 21,106	43.8%	$ 29,968
Not living alone	8.0%	$ 50,379	7.00%	$ 39,442	9.0%	$ 51,260
Male householder	46.3%	$ 35,718	45.80%	$ 27,836	47.2%	$ 35,544
Living alone	36.3%	$ 31,317	37.80%	$ 25,382	38.4%	$ 31,420
Not living alone	10.1%	$ 56,020	8.00%	$ 42,944	8.8%	$ 53,833