A Regular Meeting of the Durham County Board of Health, held January 9, 2014 with the following members present:

James Miller, DVM; Teme Levbarg, MSW, PhD; John Daniel, Jr., MD; Stephen Dedrick, R.Ph, MS; Nancy Short, DrPH, MBA, RN; Heidi Carter, MSPH; Jill Bryant, O.D.F.A.A.O; Bergen Watterson, MSCP, BA and Mary Ann Fuchs, DNP, RN, NEA-BC, FAAN.

Excused Absences: Michael Case, MPA; F. Vincent Allison, DDS; and Commissioner Brenda Howerton.

Others present: Gayle Harris, Eric Ireland, Becky Freeman, Rosalyn McClain, James Harris, Dr. Arlene Sena, Dr. Miriam McIntosh, Hattie Wood, Marcia Johnson, Will Sutton, Chris Salter Melissa Downey-Piper, Michele Easterling, Melissa Martin and Attorney Bryan Wardell.

CALL TO ORDER: - Chairman Jim Miller called the meeting to order at 5:08pm with a quorum present.

DISCUSSION (AND APPROVAL) OF ADJUSTMENTS TO AGENDA: Ms. Harris requested the following additions to the agenda.

1. Melinta Therapeutics (formerly Rib-X Pharmaceuticals) Research Study
2. Budget Amendments (3)
3. Changes-FY Board of Health Meeting Schedule

Dr. Levbarg made a motion to accept the additions/adjustments to the agenda. Mr. Dedrick seconded the motion and the motion was unanimously approved.

REVIEW OF MINUTES FROM PRIOR MEETING/ADJUSTMENTS/APPROVAL: Mr. Dedrick made a motion to approve the minutes for December 12, 2013 meeting. Ms. Watterson seconded the motion and the motion was unanimously approved.

PUBLIC COMMENTS: There were no public comments.

STAFF/PROGRAM RECOGNITION: Chairman Jim Miller recognized Dr. Nancy Short for her outstanding dedication and commitment to the board and citizens of Durham County. Dr. Short received a plaque for her service on the board.

Ms. Harris introduced Melissa Martin who will be overseeing the administrative functions in the Laboratory and Pharmacy. Ms. Harris stated since we have moved into the building with expansive bells and whistles our discipline specific folk need to learn how to work with the technology. Ms. Martin comes to us from NC State. She has a wonderful background and we are going to capitalize on all of that. Ms. Martin has worked in quality improvement and has just completed practice management training. Ms. Martin began with the department on Monday, January 6, 2014.

ADMINISTRATIVE REPORTS/PRESENTATIONS:

- **<u>2013 STATE OF THE COUNTY HEALTH REPORT</u>** ***(Activity 38.1)***

Ms. Samoff provided the Board with an overview on The 2013 State of the County Health Report. The report has a new, expanded format which presents trends over time for many key variables in addition to current statistics. The presentation discussed current findings, highlight successes, and identify needs and emerging issues. Dr. Samoff reviewed Durham

County's health priorities and the latest data. There were no significant changes in: 1) Poverty, including individuals living in poverty and populations most affected; 2) Access to Care, including uninsured adults and residents not seeing a doctor due to cost; and 3) Obesity and Chronic Illness, including physical activity, obese adults and consumption of fruits and vegetables.

There were several notable improvements. These included decreased heart disease and cancer mortality rates. Progress has also been made in Education, including increased graduation rates and decreased drug use and reported violence among middle school students.

Looking forward, there are several emerging issues for Latino County residents. These issues include less access to education, higher rates of poverty and uninsured individuals. Prescription drug abuse is another emerging countywide issue that may be impacting middle and high school students and is increasing in emergency department visits.
(***A copy of the PowerPoint presentation is attached to the minutes)***.

Comments/Questions:
Dr. Levbarg: I think the State of the County Health Report is a remarkable document and I can tell you that when you are putting together information not just for grants but I was doing a project with the Community Health Guide information that we needed about counties…and North Carolina is the only region that does this and there are a lot of places in the country and people who scan this and think "my golly" this is like having 24/7 a really good community assessment. We are doing better than other states by a mile.
Ms. Watterson: I think that one of the key concerns is that the uninsured population. Is it part of one the health department's initiatives to help people sign up for health insurance?
Ms. Harris: Yes. Lincoln Community Health Center received funds to get assistance with the process and received additional funds to house a person at the health department that will assist with contacting and helping individuals get signed up. The Department of Social Services will also house a person. Ms. Harris stated that she also received information from the Sheriff's Department on a national program that provides inmates information in case they are released.
Ms. Carter: Does the health department have a role to play around middle health services for children? That is the one need that I hear from our staff all the time…that we need more mental health support for our students.
Ms. Harris: Cheryl Scott our school health program manager can talk about her involvement. She represents us and coordinates things around mental health.
Ms. Scott: Two of the school nurses on the middle/high team participate as members of the Intervention Team, a multidisciplinary school team based on the System of Care philosophy. This team serves to provide the necessary educational supports, to include mental health supports as needed, to promote individual student success.

School nurses are able to play a pivotal role in supporting this school based team in meeting the challenges of students and families to ensure that students' physical, behavioral and mental health care needs are met in order to experience success in meeting their individual goals.

For example, school nurses are able to support the team by addressing medication concerns that impact students' behaviors, recommending additional health care resources in the community and our public health department, and assisting with the health care assessments for these students.
Ms. Carter: What is the ratio for nurses?

Ms. Harris: 1/1800 students
Ms. Carter: What we hear from teachers on a daily basis is they need training on how to support children with mental health issues.
Ms. Harris: One of the parts of Goal 2 for the County Strategic Plan is getting line staff to be able to recognize mental health issues. We have an eight hour training called Mental Health First Aid. We are sending some individuals to a conference to be certified. We would love to get into the school system to be able to give those teachers some skills so perhaps at the beginning of next school year in the developmental days we can probably schedule some training for school staff.
Ms. Carter: Someone mentioned as we have the ToothFerry we have some sort of traveling mental health van. They thought there would be a huge need for that. It is actually people that are attending the Integrated Pediatric Mental Health Board which is great but the comment I heard recently was "we need to do something to deal with the crisis now", not necessarily chronic treatment.
Ms. Samoff: What I heard is there are students that need support and then there are students that are in crisis where everybody needs support (family, teacher, facility) but the one that is first is on the destruction level.

- **CHILD FATALITY PRESENTATION** ***(Activity 9.1)***

Ms. Scott provided the Board with an overview on child death patterns and trends in Durham County and to identify potential system problems and strategies to prevent child deaths in Durham County. Ms. Scott provided a brief history of the North Carolina Child Fatality Review System; familiarized members with Durham County Child Fatality Prevention Team (CFPT) components/program requirements and discussed fatality reviews/major themes and actions taken in calendar year 2013

North Carolina has a three-tier Child Fatality Review System of which the local Child Fatality Prevention Teams (CFPTs) are one component. The local CFPTs were legislatively established in 1993. All 100 counties have a local CFPT. The mission of the local CFPTs is to review the deaths of children, ages 0 through 17, which are not due to suspected abuse or neglect and about which no report for abuse or neglect had been made to the county Department of Social Services within the previous 12 months. The local CFPTs review child deaths due to homicide, suicide, fires, illness, prematurity and perinatal causes, among others, to discuss causes and prevention of child deaths.

The purpose of local child fatality prevention team is to identify causes of child deaths, identify gaps or deficiencies that may exist in order to improve the delivery of services to children and families and to make recommendations for changes and to carry out changes that could prevent future child fatalities.

Confidential death certificate transcripts and Medical Examiner reports (if applicable) are forwarded to the Public Health CFPT Review Coordinator each quarter from the State CFPT Coordinator for the corresponding quarter of the previous calendar year. A total of forty-five child death certificate transcripts/cases were received, reviewed and discussed by the Durham County CFPT during 2013.

The Durham County CFPT met eight times to review child fatalities between January 1, 2013 and December 31, 2013 (compared to the state requirement of four times per year). The team continues to discuss strategies and activities to address risk factors to bring awareness to child fatality in Durham County. The following are of particular interest:

- Prenatal care
- Firearm safety
- Bicycle/Scooter safety

- Mental Health
- Community Education

(*A copy of the PowerPoint presentation is attached to the minutes).*

Comments/Questions:
Ms. Fuchs: Is there any benchmark data across the counties that we could compare ourselves to?
Ms. Scott: I am sure I can get that information.
Ms. Fuchs: It would be interesting to see that.
Ms. Carter: Does the death have to occur in Durham or the child just needs to be a resident of Durham?
Ms. Scott: The child is a resident of Durham.

FY 13-14 FINANCIAL REPORTS (2ND QUARTER) ***(Activity 33.6)***
Mr. Sutton provided the Board with an overview on the financial tracking information for the department's 2nd quarter spending. The following points were discussed.

- Budget Actual information provided as of 12/31/13 being the same format of the previous 1st Qtr information - By Fund Center and By Account Type
- Expenditures were at the 44% level and Revenues were at the 25% level as of 12/31/13 compared to 47% and 36% respectively last fiscal year and 45% and 31% as an average covering the past 3 fiscal years
- Percentages should be used as a guide (rule of thumb) in comparing prior year data
- Additional Revenue information:
  - Medicaid billing for the Pharmacy was just approved on 01/07/14 to transition to Patagonia, billing was stopped in November and resumed in January
  - Medicaid billing for Dental was on hold until provider ID# was addressed in December
  - Two grants ended prematurely therefore no additional revenue will be received
  - Nutrition is awaiting receipt of 90K which was requested but not received
- Feedback on the type and level of information to be presented going forward

(A copy of the 2nd quarter financial report is attached to the minutes).

Comments/Questions:
Dr. Levbarg: What I want to understand from looking at different sources of funds. Are there any places where there is neon light shining that we are in great shape or there is a concern? It was hard for me to pick up on that.
Mr. Sutton: Yes I am going to touch on that as well as to get some feedback on the kind of information and the level of detail you need going forward.
Dr. Levbarg: The question has to do with Medicaid monies and our expectation of actually receiving them. It seems to be our history of how that occurs or not has been pretty significant to our budgets in the pass. Do you have sense of what Medicaid monies are actually what we …we can bill until the cows come home…are they actually going to pay?
Mr. Sutton: We have a process in place were after you bill anything that is rejected is resubmitted. Now are you asking for some specifics as far as the specific types?
Dr. Levbarg: You were saying "we billed this and expect it to come in January". Do we experience that were the funds come in December? It is very hard to trust that system since it has been so resistant.
Mr. Sutton: The Medicaid billing is not all internal; once submitted you should receive some type of response back within 2-3 weeks. So if it is

determined that there is a problem or what we billed is different; regarding the timeline that deals with revenues received from state grants there is a huge clash with that because my understanding is we submit at the end of the month (October) in early November we put the information into the system as to what we are reporting and that gets approved then the funds are received in December. That is a huge delay in revenue received, much longer a lag time than Medicaid.
Dr. Levbarg: Maybe that is the piece that I am remembering.
Ms. Harris: We have gone through several bouts of issues with Medicaid. They changed the system at the state and then we had some staff changes and the learning and what was happening at the state didn't mesh so it took us a while to get that strait. Part of what we are doing with Patagonia transitioning from Insight to Patagonia we had a delay in doing some billing with the new system the documents or the bills should be pretty clean when they go out. If a modifier or something hasn't been put on as it is suppose to be it will be sent back to the provider to make the adjustment. Medicaid also started some time back having Medicaid recipients pay a co-pay for primary care services. Even though they granted health departments for basic health department services as an exemption the three dollars is taken off the reimbursement fee so we have to go in and look at it closely and figure out "Is this one of the services that we shouldn't have received the three dollars for. There are so many nuances that are happening at the state. What we have benefited from is the Medicaid Cost Settlement, with having gotten monies that more than offset any deficient. Fifty-two percent of the dental clinic patients are Medicaid and we just submitted the billing so we can see what happens with that.
Dr. Short: This has to do with the format of the report. On the revenue report the far last right hand column where it is labeled "percent spent" confuses me.
Mr. Sutton: Correct. It probably should have been labeled percent received or collected.

The Board requested a one-page executive summary with comparison data over a 1-2 year span as the format for ongoing financial reports.

- **PUBLIC HEALTH VACANCY REPORT** ***(Activity 37.6)***

Ms. Harris provided the Board with a copy of the December 2013 vacancy report which includes information on the currently vacant positions (22.0 FTEs) *(5 new positions, 3 resignations, 1 transfer, 1 dismissal, 5 promotions/demotions, 5 retirements and 2 grants ended)*. (***A copy of the vacancy report is attached to the minutes***)

Comments/Questions:
Dr. Short: As I was introducing MaryAnn to Hattie and MaryAnn road with me today and we were having a interesting conversation that I think the Board at large would be interested in hearing that has to do with how many new nurses that have been hired into the Duke Health System in the last year. She hired eight hundred and that is our competition for nurses. I think just hearing the number eight hundred really is important for this group to be aware of that there are nurses in the area but they are being swooped up by others. So I would really as one of my parting comments, I would really like for us to explore with the County Commissioners to be urged with comparing the salary range with the true competitor rather than other county departments.
Ms. Harris: Could we get salary ranges from you.
Ms. Fuchs: Yes. They are actually published on our website. There is a whole big process in looking at market data/conversational data that you have to look at. I'm happy to work with you around understanding what the challenges are and perhaps providing some additional information for this group to look at in the future in reference to hiring.

Ms. Harris: That would be helpful. The County Commissioners approved a class and compensation study in this current year budget. Each employee had to complete a job analysis, supervisors provided feedback on the information and then employees had to complete a education and experience document. Not only did they want to see if the needed to move the ranges up but are people positioned correctly because we have lots of compression here. On Tuesday, January 14, 2014 I have an appointment with the consultants to see where they have strategized our organization and what the recommendations happen to be.
Dr. Short: The Duke University School of Nursing has a career day for the Accelerated Bachelor Science in Nursing students once a year and I would dearly like to see the Public Health Department represented there. Every year there are one or two die hard students who want Public Health no matter what.
Ms. Harris: Hattie Wood, Director of Community Health/Nursing will be there.
Ms. Wood: Do you know the date?
Dr. Short: I don't know the date but I can send it to you.

- **NOTICES OF VIOLATIONS (NOV) REPORT** ***(Activity 18.2)***

The Board received a copy of the Environmental Health Onsite Water Protection Section NOV report for December 2013. The report documents notices of violations issued to property owners who are noncompliant with the "Laws and Rules for Sewage Treatment and Disposal Systems. (***A copy of the December 2013 report is attached to the minutes)***

- **NEW PARTNERSHIP WITH PARTNERSHIP FOR SENIORS** ***(Activity 41.2)***

Ms. Harris requested the Board support in creating a new position to work with Durham Partnership for Seniors and partners in the disability services community to: 1) build upon the work of these groups; and 2) to create a Durham-based CRC (Community Resource Connection) for seniors and adults with disabilities. Melissa Black will begin on Monday, January 13, 2014 to assist in writing the Community Health Assessment document with a special focus on seniors.

Background:
According to census data, the population of Durham County residents who were 60 and older in 2010 was 38,779 or 14.5% of the total population. This age cohort is projected to grow to 71,471 or 18.8% of the County's population by 2030 (NC Division of Aging and Adult Services County Profile posted 2/2012). This projected growth is 2.5 faster than other age groups in Durham. The agencies that work with older adults need to collectively "gear up" for this massive growth, ensuring that we have a variety of services to meet the disparate needs of the "new" seniors and their aging neighbors.

- Even now – there are many seniors on waiting lists for services that could greatly enhance their lives. While we must plan for the future, we also have to take stock in how to best use our resources now. If we continue to operate in silos and think only "inside our boxes," we will continue to have many older adults who fall through the cracks of our senior safety net.
- In addition, there are thousands of adults with physical and/or developmental disabilities who also struggle to find the supports they need to remain as healthy and independent as possible in Durham. A CRC is mandated to provide resources and referral to adults with disabilities. While there is a commonality of needs between both the aging and disability populations, people with disabilities have specific and unique assets to bring to our work. The US Department of Health and Human Services estimates that at least 18% of the adult population has a disability.

- Many communities in North Carolina and indeed across the nation have responded to the growing aging population and the challenges faced by younger people with disabilities – in a collaborative community-based response by creating what is nationally called ADRCs (Aging and Disability Resource Centers). The effort in NC is dubbed CRC or Community Resource Connections highlighting the fact that a web of connected providers and services are needed to meet our challenges. Both Wake and Orange/Chatham have CRCs in place and we understand that $15,000 in state funding is available now to help create a CRC in Durham; however, this opportunity may be fleeting. The hope is that the State will continue to fund these collaborative networks moving forward.
- Durham's Commissioners have individually endorsed Durham developing a CRC (Durham CAN assembly - Fall 2012). And fortunately, Durham does not have to start from scratch as the Durham Partnership for Seniors and partners in the disability services community have been doing similar work for years.

What is a Community Resource Connection (CRC)?
A partnership/coalition/collaborative that:

- Joins the aging and disability communities to coordinate commonalities and system overlap, while also acknowledging differences and system gaps
- Enhances the availability of and outreach about resources to underserved populations.
- Honors memorandums of understanding that create a user-friendly and practical "no wrong door" system of care where seniors and people with disabilities (and the family members and people in agencies who work with them) can access information about the services they need.
- Uses technology effectively to both streamline access (i.e. Web-based resource databases, online applications & decision support tools) and creates administrative efficiencies (i.e. exchanging eligibility as appropriate across partner agencies)
- Focuses on consumer needs and satisfaction such that seniors and persons with disabilities understand their options and have access to the information they need to make good choices
- Creates shared accountability when appropriate and shares in the decision-making and credit when applicable but also confronts challenges together; agencies and programs retain their sovereignty while also operating together within the CRC.

Why is a Coordinator needed?

- Like the Partnership for Healthy Durham, which has a coordinator housed in the Durham County Department of Health, the Durham Partnership for Seniors (DPfS) and the disability services community believe that a coordinator focused on developing, implementing and sustaining a CRC in Durham will move our collective efforts forward at a critical time. We are challenged to better understand and then address the growing needs of seniors and adults with disabilities in our community.
- The DPfS is a well-established group, comprised of agency leaders and interested community members that have historically focused on senior issues. Recently, the group has expanded to include agencies and individuals who also serve younger people with disabilities. For years, DPfS has been the coalition responsible for making funding recommendations about state block grants for aging services to the Durham County Commissioners. This coalition also served as the United Way's senior issue team for several years and more recently, as the City- County "results-based accountability" team for seniors issues and Durham Health

Innovation's senior planning team. The momentum of this group is growing with new partners joining in our efforts: including Durham CAN, Durham Cares, First in Families; Long Term Care Ombudsman program; CAARE clinic; Senior Health Support of the Triangle, and others. Long-standing members include Triangle J Area Agency on Aging, Durham County Department of Health, Durham County DSS Adult Services; Durham Center for Senior Life, Senior PharmAssist, Meals on Wheels, RSVP, A Helping Hand, Project Compassion, members of various faith communities, long-term care providers, Durham Community Health Network with the Duke Division of Community and Family Medicine, and others. We realize that meaningful change will be necessary if we are to rise to the challenges of a booming aging population, shrinking resources for people with disabilities, and a trend towards limited governmental funding. We have to "do more – with less." Collaborative planning and shared knowledge and resources are some of the methods for combating these negative trends. We understand that together we can accomplish much more than if we each work in isolation.

- We believe that the CRC Coordinator could physically be housed in the Durham County Department of Health – Division of Health Education – so s/he can work closely with the Partnership for a Healthy Durham Coordinator. They can both learn and share best practices for coalition-building, use of demographic statistics, shared accountability, and how to strategically move the Durham community forward in our efforts to make Durham a healthier place to live, work, and play for all ages and abilities. The fiscal oversight for the position would be identical to the CRCs in Wake and Orange/Chatham as it would be the responsibility of the Triangle J Area Agency on Aging. Their expertise and leadership will be invaluable. The CRC Coordinator will work with the DPfS and the disability services community to determine how to proceed with the CRC application and implementation.

HEALTH DIRECTOR'S REPORT

December 2013

Division / Program: Community Health Division / Communicable Disease Program
(Accreditation Activity 7.2- Conduct communicable disease investigations, follow-up, documentation, and reporting activities.)

Program description

- Conduct thorough reporting and investigation of all reports of communicable disease (including outbreaks) and to implement prompt communicable disease control management to protect the health of the community.
- Ensure compliance with North Carolina's communicable disease statutes and rules through implementation of appropriate control measures, education of providers, and education of the community.

Statement of goals

- To investigate reported cases of communicable disease in Durham County
- To ensure appropriate control measures are implemented to prevent disease transmission
- To provide timely and accurate education and information to all involved, such as ill patients, schools, parents, healthcare providers, media, community at large, and others as indicated

Issues

- **Opportunities**
  - One confirmed case of Crytosporidiosis in a 17 year old swim team member from Orange County; the swim team was known to have practiced in at least 3 different Durham County pools
  - Five confirmed cases reported in Durham County; all members of the same swim team
  - Pools located in Wake and Guilford counties were also used by swim team
- **Challenges**
  - To work with Orange County Communicable Disease staff, the affected swim team coach, members, and their families, private and public school athletic directors, state public health, DCoDPH and Orange County Environmental Health, and involved others to
    - quickly identify those at risk for infection, location of affected pools, dates of
    - swim meets and practices
    - stop the chain of disease transmission as quickly as possible
    - to prevent disease transmission to others in the community
  - To obtain contact information for swim coaches, parents, schools, pool operators, healthcare providers, and others in order to provide accurate and timely information
  - To provide accurate information to the media upon request

Implication(s)

- **Outcomes**
  - Five confirmed cases and five probable cases investigated in Durham County and reported to state public health
  - Control measures issued to ill swimmers/parents, as well as to swim coaches, school athletic directors, pool operators, healthcare providers, media, and community at large
  - Six affected pools in Durham County contacted by DCoDPH Environmental Health (EH) with a recommendation to close for cleaning and hyper-chlorination
  - Regular consultation conducted with Orange County CD and EH staff and state public health re: notifications and letters to be distributed to affected swimmers and families
  - Educational Information provided to Durham City Parks and Recreation department for posting at pool locations
- **Service delivery**
  - Communicable disease nursing staff fielded numerous calls from concerned parents, schools, healthcare providers, and others during a two week period (Dec 5-20)
  - Information provided to the media by DCoDPH in the form of an on-camera interview, written and verbal updates
  - Information and education regarding cryptosporidiosis provided via informational letters to swim team coaches, swimmers, families; pool operators; healthcare providers; school athletic directors, and others as needed
- **Staffing**
  - Response involved internal communication and collaboration among Communicable Disease nursing staff, Communicable Disease Program Manager, Medical Director, Community Health Division Director, Deputy Health Director, Information and Communications assistants, School Nursing, and Environmental Health staff.
  - Community communication and collaboration involved the affected swim team, members, and their families, local private

and public school coaches and athletic directors, healthcare providers, state public health

Next Steps / Mitigation Strategies

- Communicable Disease Nursing staff will continue to monitor for and investigate reported cases of cryptosporidiosis in Durham County
- Environmental Health staff will continue to work with local pools to ensure adequate chlorination is provided in order to prevent transmission of disease

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Division / Program: Dental Division / Access to Dental Care for Adult Patients
(Accreditation Activity: 20.1- Collaborate with community health care providers to provide personal and preventative health services.)

Program description

- The Dental Division has collaborated with Project Access Durham to offer dental screenings to uninsured adults in need of care. A volunteer dentist completes screenings at the Department of Public Health. Based upon the screening results, Project Access then makes a referral to a local dentist that has agreed to treat patients at no cost.
- After a successful pilot program last spring, the Division has scheduled two afternoon sessions each month, December through June, 2014. Project Access refers the adult to a local dentist that has agreed to treat patients at no cost.

Statement of goals

- To increase access to dental care to uninsured adult populations in Durham County.
- To work collaboratively with community partners to highlight the need for oral health services for uninsured patients.

Issues

- **Opportunities**
  - Offering dental screenings to adults who may not otherwise receive treatment due to their being uninsured.
- **Challenges**
  - Currently, the program is only scheduling eight adult patients per month. The clinic is exploring screening patients another hour each week, which will allow us to see six additional patients. In addition, there have been discussions with Project Access Durham about bringing in another volunteer dentist.
  - At present, the patients are referred from Project Access Durham. The clinic frequently receives queries from other adults looking for treatment.

Implication(s)

- **Outcomes**
  - The clinic screened seven adults in December (six were 46+ years of age).
- **Service delivery**
  - Patients receive an evaluation, including x-rays and treatment plan.
- **Staffing**
  - The Dental Division provides up to two dental assistants for the project, to take x-rays, chart notes, etc.

Next Steps / Mitigation Strategies

- o Review Dental Assistant schedules and work flows to evaluate internal capacity
- o Continue discussions with Project Access regarding an additional provider to screen adults.

Division / Program: Nutrition Division / Community Transformation Grant Project Healthy Eating Videos
(Accreditation Activity 12.3- Participate in a collaborative process to implement population-based programs to address community health problems.)

Program description

- The Department has teamed up with the Region 5 Community Transformation Grant Project (CTGP) staff to create two 25 minute videos about healthy eating that feature and is co-created by Durham youth.

Statement of goals

- To communicate the importance of healthy eating.
- To link residents with local resources to improve their nutrition.
- To highlight Durham programs that are working to make it easier for Durham residents to eat healthier.

Issues

- **Opportunities**
  - o The video planning and production processes are creating stronger partnerships between DCoDPH, CTGP staff, SEEDS Community Garden and Durham Together for Resilient Youth (Durham T.R.Y.)
  - o By filming the videos through the eyes of youth, we are likely to catch more attention and viewers than if adults were featured in the films.
  - o Assistant County Manager Deborah Craig Ray said it was likely that the videos could air on the Durham Access Channel.
- **Challenges**
  - o Coordination of youth and other components needed for video production.

Implication(s)

- **Outcomes**
  - o Two videos will be produced. The videos will hopefully air on Durham Access Channel and be available on YouTube.
  - o The first video features the value of eating locally grown foods. Youth employed by SEEDS Community Garden wrote the script and filming occurred at the Downtown Durham Farmers' Market.
  - o The second video will be a documentary in which youth associated with Durham T.R.Y. will work with a corner store to increase the number of healthy foods sold and help the store better market the healthy items.
- **Staffing**
  - o A DCoDPH Nutrition Program Manager has been involved in the development, planning, working with the youth, script development, and filming of this project.

Next Steps / Mitigation Strategies

- Work with the corner store manager to develop the healthy store project.
- Film the corner store video with the youth from Durham T.R.Y.

- Advertize both videos with a press release and on various websites and listserves (Durham Farmers Market, CTGP region 5, SEEDS Community Garden, Durham T.R.Y, DCoDPH).
- Work with Deborah Craig Ray to get the videos aired on the Durham Access Channel.

Division / Program: Nutrition Division / Clinical Nutrition Services (Accreditation Activity 10.1- Develop, implement and evaluate health promotion activities designed to influence the behavior of individuals and groups)

Program description

- Medical Nutrition Therapy (MNT) is provided at the Durham County Health Department.
- A target population for the DCoDPH Clinical Nutrition program is children in Durham County.

Statement of goals

- To increase the health of children in our community by providing MNT to school aged children and their families through nutrition clinic visits, home visits, and consultations with other health care professionals.
- To support the Healthy North Carolina 2020 Objective: "Increase the Percent of High School Students Who are Neither Overweight nor Obese".

Issues

- **Opportunities**
    - The most common referral reason for school aged children to the Nutrition Clinic is overweight status.
    - Latest data from the State of the County Health Report for 2012 reports 30% of high school students in Durham County are overweight or obese.
    - The target population for DCoDPH MNT intervention is all school aged children in K-12 grades.
    - Research and clinical experience shows that intervening with children can lead to lasting changes to improve life-long health.
- **Challenges**
    - Reaching school age children and their families outside of school hours is frequently problematic.
    - Normal Monday through Friday clinic hours are difficult times for appointment scheduling for school age clients and their families.

Implication(s)

- **Outcomes**
    - In FY 2012-13, the Clinical Nutrition program conducted 273 initial or follow up MNT appointments for children and completed 539 child-related consults and public inquiries.
    - Clinical Nutritionists work with pediatricians, schools, and local programs such as Duke's Healthy Lifestyles program and East Durham Children's Initiative (EDCI) to coordinate patient care and strive for best outcomes for clients.
- **Service delivery**
    - The Nutrition Clinic is open for clients by appointment and for consultations during normal business hours of DCoDPH. Home visits are scheduled for children as needed so that all children can benefit from nutrition services.

    - Referral sources for MNT services include pediatricians, schools, parents, social workers, pediatric and family-focused community agencies.
- **Staffing**
    - The Clinical Nutrition staff includes 5 Registered Dietitians and Licensed Dietitians/Nutritionists who provide MNT and nutrition consultations.
    - At least one Registered Dietitian staffs the Nutrition Clinic Monday through Friday, 8:30 am- 5:00 pm and on Tuesday until 7:00 pm.
- **Revenue**
    - MNT is a billable service. DCoDPH is a MNT provider for BCBS, Medicaid and Duke Select/Basic. Clients not covered under these plans are covered under a Special Nutrition Grant from the NC Department of Health and Human Services.

Next Steps / Mitigation Strategies
- Continue to identify potential referral sources within the health care community to assist in reaching school age children with a diagnosis of overweight or obesity.
- Continue outreach to families and health care providers, case managers, therapists, and schools in the community to ensure the children of Durham are best served.

Division / Program: Administration / Information and Communications

Program description
- The Information and Communications program provides accurate, timely, and relevant information to the residents of Durham County on key health issues as well as informing the public about department programs and services availability. Information is disseminated in many forms, included broadcast, print, and multimedia (web-based).

Statement of goals
- To increase the public's awareness and understanding of important health information and the Department of Public Health's programs and services availability
- To increase the public's utilization of the Department of Public Health's programs and services.
- To become the main, trusted and dependable choice for journalists seeking information and assistance to develop compelling and balanced stories on Public Health issues.

Issues
- **Opportunities**
    - With staff dedicated to information and communications, the Department of Public Health can provide more information to the public on health issues
    - Media/reporters are eager to use information provided to them by the Department of Public Health for their viewers/readers. Television and radio announcers often request follow-up information and interviews.
- **Challenges**
    - Prioritizing the topics to publicize
    - Staff balancing external media requests with internal needs to review/revise/develop new media to promote programs and services.

Implication(s)

- **Outcomes**
  - Information and communication about health issues and department programs and services are being publicized in a timely, organized manner and with greater frequency.
  - Visibility of public health information from the department has substantially increased.
- **Service delivery**
  - As of December 27, disseminated two (2) media releases/advisories during the month of December (one of these, a joint release with Orange County Public Health) and responded to nine (9) direct inquiries from reporters, resulting in 37* unique media postings/airings (television), printed in the news, or posted to the web. These included coverage of a multi-county cryptosporidium outbreak, Durham County's World AIDS Day event, flu cases on the increase, skin care for diabetics, and other topics. **(Accreditation Activity 5.3- Health Alerts to Media; 9.1- Disseminate Health Issues Data; 9.5- Inform Public of Dept. / Op. Changes; 10.2 Health Promotion –Disease Prevention; 21.2- Make Available Information About LHD Programs, Services, Resources)**
    **This total may increase as more coverage continues from the cryptosporidium outbreak.*

Next Steps / Mitigation Strategies

- Continue building/developing various communication channels as well as the Department of Public Health's delivery of information and communications.

Division / Program: Environmental Health/Public Health Preparedness
(Accreditation Activity 7.4: The local health department shall have a public health preparedness and response plan.)
Program description: (DCoDPH Strategic National Stockpile Plan)

The plan is a response to events such as terrorist attacks, disease pandemics, or major disasters that result in rapid depletion of critical medical supplies on the local and state levels. The Federally established Strategic National Stockpile (SNS) augments local supplies and is managed by the Centers for Disease Control (CDC). Supplies may consist of large quantities of medicines, antidotes, and medical supplies needed to respond to a wide range of expected problems or scenarios. The plan describes how Durham County requests, receives, manages, repackages, and distributes the SNS to those who need it within the jurisdiction via the Local Receiving Site (LRS). This includes all of Durham County.
Statement of goals:

- Develop and execute a table top exercise that addresses each of the required elements of the response plan while generating open discussion, identification of shortfalls, and problem resolution that results in a more refined and effective activation of the Durham County SNS and LRS Plan(s). Exercise took place on December 17, 2013.

Issues:

- **Opportunities**
  - Participating staff were able to identify multiple methods of call down, possible sources for needed accommodations and provisions, and possible sources for needed refrigeration

- **Challenges**
  - Activation of the plan requires flexible and dedicated staff. Efficient and effective call down of staff is paramount to success
  - Multiple shifts may be needed resulting in the need for accommodations and provisions
  - LRS sites may not be equipped with adequate refrigeration needed to properly hold certain antidotes and medications

Implication(s)
- **Outcomes**
  - Problems, concerns and solutions were identified
  - Increased familiarity with order of events, individual responsibilities, and enhanced awareness and confidence of participants
  - Satisfied training and exercise requirements
- **Service delivery**
  - Staff will be capable of more rapid and effective activation of the SNS and LRS Plan(s)
- **Staffing**
  - Members from General Inspections, Onsite Water Protection, and Administrative sections of the Environmental Health Division are tasked with staffing requirements of the plan
- **Revenue**
  - Execution of the table top exercise satisfies training requirements needed to sustain critical grant funding to the department

Next Steps / Mitigation Strategies
- Continued training that addresses specific details of participants "Job Action Sheets" will occur
- Plan refining and improvement are ongoing and dynamic

COMMITTEE REPORTS:
- **NOMINATION COMMITTEE RECOMMENDATION**

The Nominating Committee made a motion to recommend Dr. Jim Miller, as Chair and Teme Levbarg, PhD, as Vice-Chair to the Board. Dr. Miller accepted the position as Chair and Dr. Levbarg accepted the position as Vice-Chair to the Board. The board unanimously approved the nomination.

- **PERSONNEL COMMITTEE** (***Activity 37.4 & 37.5***)

Dr. Levbarg reported that the committee is in the process of updating all pertinent information. The next step in the process is to send the evaluation questionnaire out on survey monkey. Dr. Levbarg will contact each committee member on the progress. The committee will meet with Ms. Harris once all information is collected and compiled to discuss her evaluation and then the Board will send the final recommendation to the County Manager.

OLD BUSINESS:
- **E-CIGARETTES** ***(Activity 34.5)***

Dr. Daniel suggested that the Board wait until the FDA comes out with their statement/position on E-cigarettes before the Board makes a determination. The Board will continue to gather and review reference documents on E-cigarettes. ***A copy of reference documents are attached to the minutes***).

Comments/Questions:
Dr. Short: To be clear, we would be talking about water vapor smoking (water vapor pipes, cigarettes etc) that have nicotine in them because we

are not going to step over that line into water vapor smoking that has no nicotine in it.
Dr. Levbarg: I think we are being very specific about e-cigarettes here.
Dr. Short: With nicotine.
Dr. Levbarg: That is what they all have in them and to the best of what I have seen so far they all produce smoke of some sort that would be considered a source of hazard.
Ms. Carter: I think the other thing that we could do is pass an ordinance or something that would prohibit the sale of flavored e-cigarettes to minors.
Ms. Harris: That is a state law.
Ms. Carter: Terrific
Ms. Harris: We can do some education.
Chairman Miller: Does the present rule include e-cigarettes in it some way or is it unclear?
Attorney Wardell: I don't think it is clear. I think we were focusing on second-hand smoke and it is very little second-hand smoke with the e-cigarette. That is where we may have a bit of an issue because you can smoke; you just can't smoke in a place that is relevantly public. You can smoke in your house or car because you are doing whatever you are doing to yourself and so it seems that e-cigarettes, if there is any hazard it is more of a hazard to the individual that is smoking it as to oppose to some third party or public health issue. So I think that is where you will have some problems in terms of regulating.
Dr. Levbarg: One of the articles did talk about second hand smoke.
Attorney Wardell: Yes. It said one percent of an enclosed area.
Ms. Harris: They usually refer more to vapors rather than smoke. The term is "vaping". I think one of the beach counties (Pender County) tacked on to their rule "no vaping".
Chairman Miller: I think continuing to gather information and move the direction we are going to make sure we understand the CDC position.
Attorney Wardell: It is probably more of a educational issue oppose to a regulatory issue. The rule is a regulatory tool and so I say this may be more of an educational.
Dr. Levbarg: I think we need to keep this on our radar screen.
Ms. Carter: You will be happy to know that children in Durham Public Schools are not allowed to have e-cigarettes on campus.
Dr. Levbarg: So in order to keep this on our radar is to after the FDA comes out with its…and we can start to compile NACCHO, FDA, CDC and DHA response so we can look at some sense of how they are rating in on this. That will keep our conversations appropriate and then maybe we will be able to understand whether is honestly any action we need to take.
Chairman Miller: Is there a way to have someone within the health department to be the point person to keep that or our radar.
Ms. Harris: Melissa Downey-Piper, Director of Health Education has staff that already works with tobacco related activities so they could keep us apprised.

NEW BUSINESS:

- **BUDGET AMENDMENTS**

The Board is requested to recognize and approve funds in the amount of $20,833 from the NC Department of Health and Human Services Division of Public Health to establish a local site within the statewide safe spaces network for carrying out the programmatic, logistical and administrative functions of the Safe Spaces group intervention. A part-time facilitator will be hired for the purpose of identifying and recruiting HIV positive minorities to assist them in reducing their viral load and CD4 count.

The Board is requested recognize and approve funds in the amount of $27,430 from NC DHHS, Division of Public Health to continue the TANF Out-Of- Wedlock Birth Prevention Program in Durham County. These funds are to be used to implement strategies devised to serve the

community's needs relative to the prevention of out of wedlock births among TANF-eligible clients and among those at risk of becoming eligible as a result of unintended pregnancies.

The Board is requested to recognize and approve funds in the amount of $6,789 from the NC Department of Health and Human Services Division of Public Health to develop and implement policy, systems, and environmental change interventions that improve local food systems, increase food security, promote active living through planning, reduce and prevent tobacco use, and prevent chronic diseases, violence and injury.

Ms. Carter made a motion to recognize and approve the aforementioned budget amendments. Mr. Dedrick seconded the motion and the motion was unanimously approved.

- **MELINTA THERAPEUTICS GONORRHEA RESEARCH STUDY**

Dr. Sena provide the Board with an overview on a new research study to be conducted in the STI clinic by UNC-CH research staff, entitled "A Comparative Evaluation of the Single-Dose Efficacy of Oral Delafloxacin Versus the Single-Dose Efficacy of an Intramuscular Injection of Ceftriaxone in Subjects with Uncomplicated Urogenital Gonorrhea.

The study involves proprietary information about an investigational drug for treatment of gonorrhea. Infections due to Neisseria gonorrhoeae are a public health emergency due to the progressive development of antibiotic resistance. The proposed study will involve a comparative, open-label, single-dose, multi-center study involving an investigational fluoroquinolonone, delafloxacin, which exhibits excellent in vitro activity against N. gonorrhoeae, including ciprofloxacin-resistant isolates. The drug has been shown to have similar potency as ceftriaxone (standard treatment) for gonorrhea. The most frequent drug-related adverse events reported from the phase 1-2 studies include nausea, vomiting and diarrhea. In general, the drug is report to be well tolerated. The study will recruit men and women >18 years of age with presumptive or confirmed gonorrhea, or sexual contact with a person with gonorrhea in the past 2 weeks. Study participants will have additional specimens for gonorrhea testing and will be randomized to receive either ceftriaxone or study drug. Subjects will be followed for adverse events, and asked to return for a test to cure.

The resources to be requested from Durham County Department of Public include:

1. Referral from STD clinicians regarding potentially eligible patients with gonorrhea or contact to gonorrhea;
2. Space for recruitment, enrollment and follow-up;
3. Space for storage of study drug and gonorrhea cultures

Ms. Carter made a motion to endorse the new gonorrhea research study. Dr. Levbarg seconded the motion and motion was unanimously approved.

- **2014 BOARD OF HEALTH MEETING CHANGE**

Mr. Dedrick made a motion to change the scheduled June 12, 2014 meeting to June 19, 2014 and cancel the July 10, 2014 meeting. Ms. Watterson seconded the motion and the motion was unanimously approved.

- **AGENDA ITEMS-FEBRUARY 2014 MEETING**

  Annual Communicable Disease Report
  Environmental Health Septic System Presentation

INFORMAL DISCUSSION/ANNOUNCEMENTS:

FY 14-15 Budget Meeting-Tuesday, February 25, 2014 at 5pm

Mr. Dedrick made a motion to adjourn the meeting. Ms. Watterson seconded the motion and the motion was unanimously approved.

____

Jim Miller, DVM-Chairman

____

Gayle B. Harris, MPH, Public Health Director

Partnership for a Healthy Durham
A Certified Healthy Carolinians Partnership

State of the County Health Report 2013

Erika Samoff MPH PhD
Epidemiologist and Coordinator
Partnership for a Healthy Durham

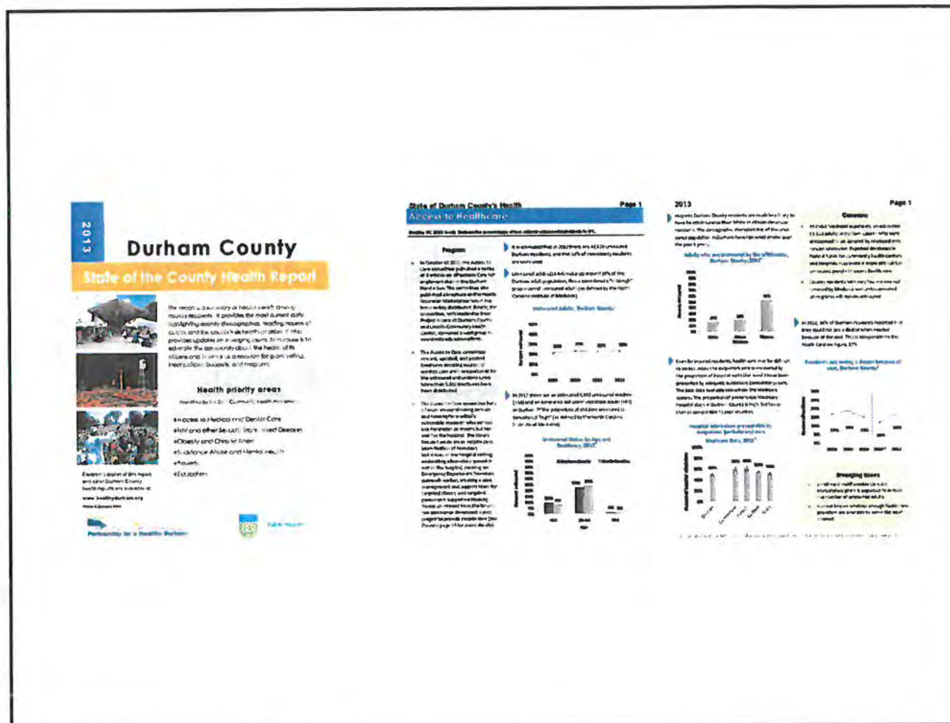
What is the SOTCH for?

- Inform Durham County citizens
- Provide information for planning and grant-writing
- Report on progress toward health goals

Reporting on health goals

- Health goals
  - Defined during community health assessment process
  - Healthy NC 2020
  - Linked to County and DCoDPH strategic plans

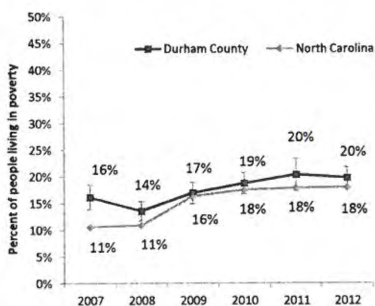
- Specific objectives and action plans available at www.healthydurham.org - Committees

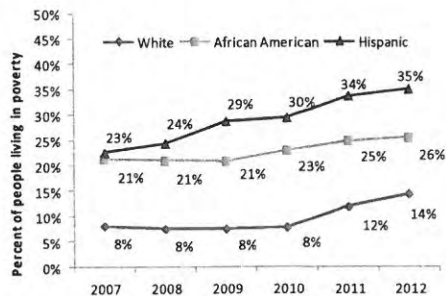


Findings

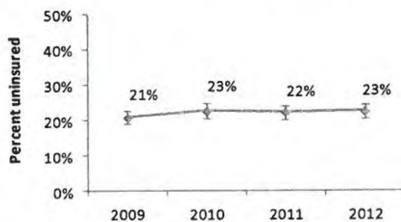
What didn't change in 2013?

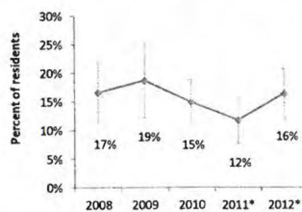
Poverty (pages 12-13)





Access to Care (pages 4-5)



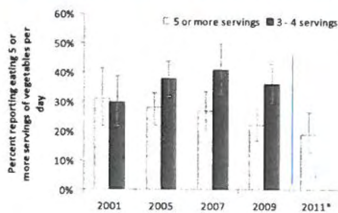


The Affordable Care Act should change these numbers in 2014

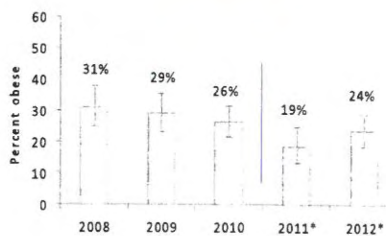
– may not be visible until 2015

Obesity and Chronic Illness (pages 8-9)

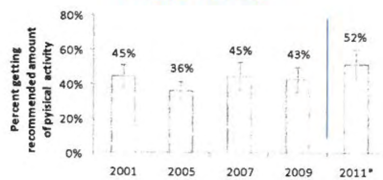
Consumption of fruit and vegetables



Obese Adults



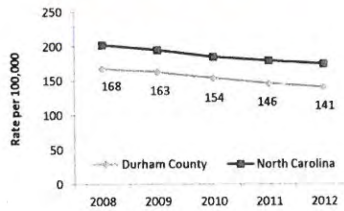
Physical Activity

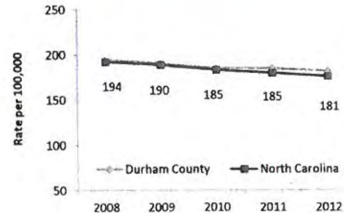


*Because of changes in BRFSS data collection in 2011, data from 2011 and later are not comparable to previous years.

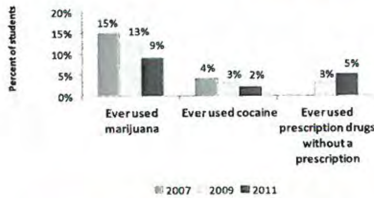
What got better?

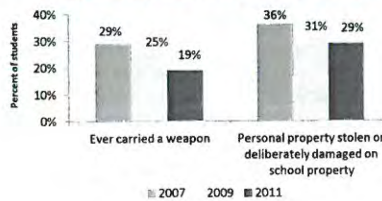
Obesity and Chronic Illness (pages 8-9)

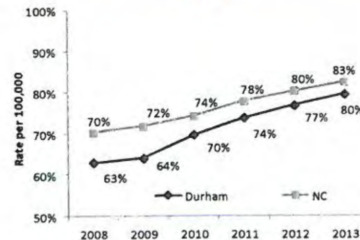




Education (pages 14-15)





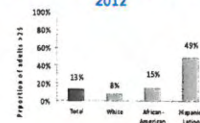


What key concerns appear?

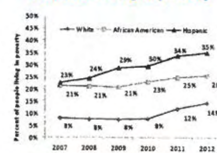
Latino Durham County residents

- Less access to education
- Higher rates of poverty
- Lower % insured

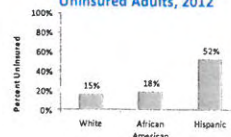
Percent of adults with no high school diploma, 2012



Individuals living in poverty

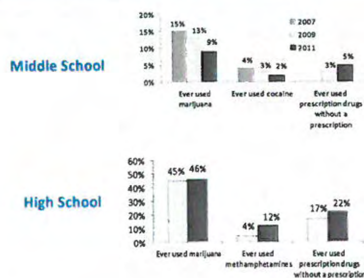


Uninsured Adults, 2012

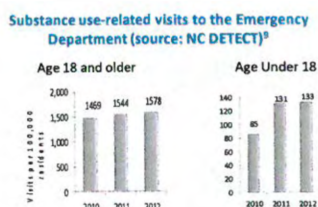


Prescription drug abuse

- Possible increase in prescription drug use in middle and high school



- Increase in substance use-related visits to the Emergency Department



What are we doing about it?

New Initiatives

Environmental changes

- Healthy Mile Trails
- The Healthy Aisle program
- Collaborations with the Veggie Van and the Durham Farmers Market

New Initiatives

Expanded access to chronic disease screening and care

- Screening for Hepatitis C virus
- Durham Diabetes Coalition
- Low-cost dental care for adults

- Familiar Faces initiative
- Pediatric mental health

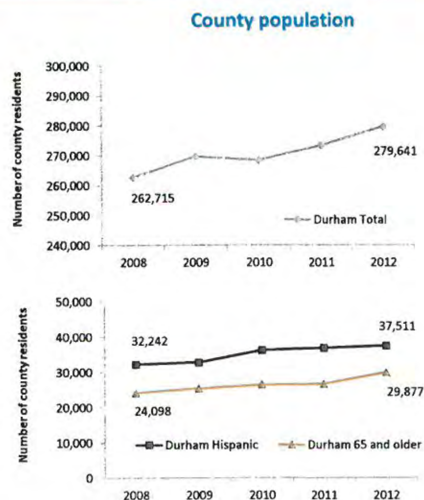
Questions?

esamoff@dconc.gov

919-560-7833

County population

- Since 2008, county population has grown by an estimated 16,926 residents
- Hispanic/Latino population: 5,269
- Population 65 and older: 5,779



2013

Durham County

State of the County Health Report

This report is a summary of health trends among county residents. It provides the most current data highlighting county demographics, leading causes of death, and the county's six health priorities. It also provides updates on emerging issues. Its purpose is to educate the community about the health of its citizens and to serve as a resource for grant writing, local policies, budgets, and programs.

Health priority areas

Identified by the 2011 Community Health Assessment

- Access to Medical and Dental Care
- HIV and other Sexually Transmitted Diseases
- Obesity and Chronic Illness
- Substance Abuse and Mental Health
- Poverty
- Education

Electronic copies of this report and other Durham County health reports are available at:

www.healthydurham.org

rinted January 2014

Partnership for a Healthy Durham

Public Health

100 Years of Service • 1913-2013

Durham's Demographics and Health

The estimated 2012 population of Durham County is 279,641.[1]

Durham County Population[1]

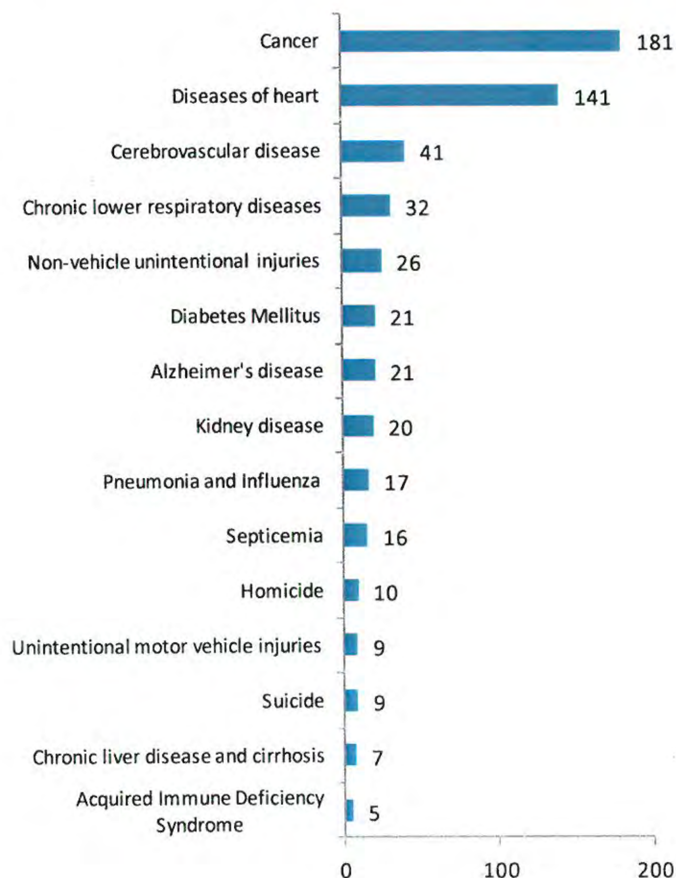
Gender	Number of residents	Percent of total population
Male	133,566	48%
Female	146,075	52%
Race/Ethnicity		
White	151,321	54%
Black or African American	108,974	39%
American Indian	2,991	1%
Asian	16,205	6%
Other race	8,340	3%
Hispanic (of any race)	37,511	13%
Age		
<18	63,253	22%
18-64	186,511	67%
>64	29,877	11%

Overall Health Indicators[2]

- 86% of Durham County residents reported being in excellent, very good, or good health in 2012.
- 81% of Durham County residents reported fewer than 3 poor physical health days in the past month.
- 77% of county residents reported fewer than 3 poor mental health days in the past month
- Life expectancy for someone born in Durham County in 2009-2011 was 79 years.

Leading Causes of Death, Durham County, 2008-2012[3]

Age-adjusted death rates per 100,000 population



Durham's Successes and Assets

Durham County Strategic Plan Health Goals

- Decrease health disparities within the community
- Strengthen the well-being of individuals and families through prevention and education
- Partner with community resources to increase access to health and wellness services

Healthy NC 2020 Objectives[4,5]

- North Carolina has set 40 statewide health objectives with targets to reach by 2020.
- Durham County currently meets or exceeds 7 of the Healthy NC 2020 Targets.[4] We have better conditions for children: lower rates of smoking during pregnancy and better dental services; and better conditions for adults: fewer alcohol-related traffic crashes, unintentional poisonings, and adults with permanent teeth removed or with diabetes; and we also have a lower suicide rate than the NC 2020 goals.
- Durham County's infant mortality rate has continued to decrease, from 7.0 in 2010 to 6.7 in 2013 (the Healthy 2020 goal is 6.3). Teen pregnancy rates also continue to decrease. However, the gap between infant mortality among African Americans and Whites continues to exist; infant mortality among African Americans (14.3 per 100,000) was 2.75 times that among Whites (5.2 per 100,000).

New Initiatives

Environmental changes to support positive health choices

The Healthy Mile Trail program uses sidewalk stencils to identify one mile walking trails in neighborhoods. These permanent markers support physical activity in a way that's cost-effective and close to home.

The Healthy Aisle program changes what is stocked on checkout aisle shelves, to make purchases of unhealthy food more difficult and purchases of healthy snacks easier.

Collaborations with the Veggie Van (which offers a CSA from the Human Services Building), and the Durham Farmers Market (to support accepting EBT (food assistance cards)) make local, fresh vegetables available to more members of the community.

Expanded access to chronic disease screening and care

Screening for Hepatitis C virus is being offered at the Durham County Department of Public Health onsite and at the Durham County Detention Center, TROSA, and other settings. This program has tested over 1,700 people and linked more than 50 people testing positive to medical care at Duke University or the University of North Carolina.

The Durham Diabetes Coalition, a partnership of health and community organizations, is working to offer support to those diagnosed with type 2 diabetes and those who have type 2 diabetes but aren't yet diagnosed.

To expand access to low-cost dental care for adults, Project Access of Durham County and the Department of Public Health partnered to conduct a pilot project to provide uninsured adult patients with donated dental care. This project will be expanded in 2014.

Access to Healthcare

Healthy NC 2020 Goal: Reduce the percentage of non-elderly uninsured individuals to 8%.

Progress

- In October of 2013, the Access to Care committee published a series of 4 articles on Affordable Care Act implementation in the Durham Herald-Sun. The committee also published a brochure on the Health Insurance Marketplace which has been widely distributed. Finally, the committee, with leadership from Project Access of Durham County and Lincoln Community Health Center, convened a workgroup to coordinate education efforts.

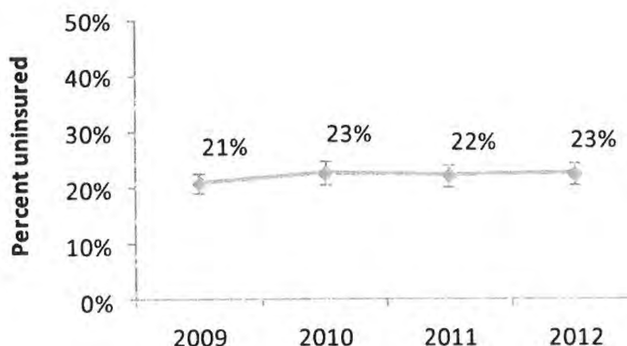
- The Access to Care committee revised, updated, and printed brochures detailing sources of medical care and transportation for the uninsured and underinsured. More than 5,000 brochures have been distributed.

- The Access to Care committee held a forum on coordinating services and housing for medically vulnerable residents who are too sick for shelter or streets but too well for the hospital. The forum focused on six areas: respite care, identification of homeless individuals in the hospital setting, embedding a homeless specialist within the hospital, creating an Emergency Department homeless outreach worker, creating a case management and support team for targeted clients, and targeted permanent supportive housing. Based on interest from the forum, the committee developed a pilot project to provide respite care (see Poverty page 14 for more details).

It is estimated that in 2012 there are 47,620 uninsured Durham residents, and that 19% of non-elderly residents are uninsured.

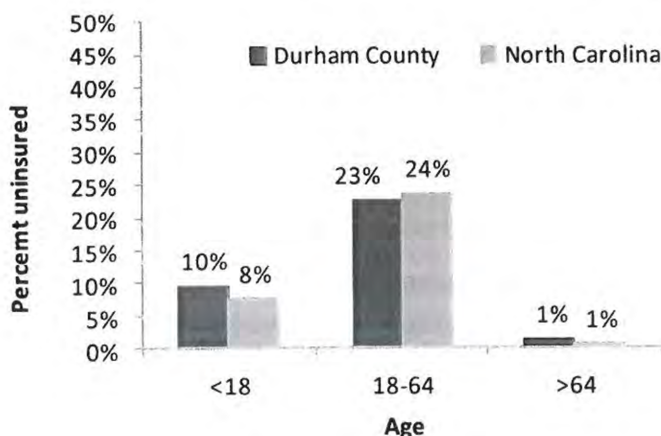
Uninsured adults (18-64) make up around 20% of the Durham adult population; this is considered a "mid-high" proportion of uninsured adults (as defined by the North Carolina Institute of Medicine).

Uninsured Adults, Durham County[6]



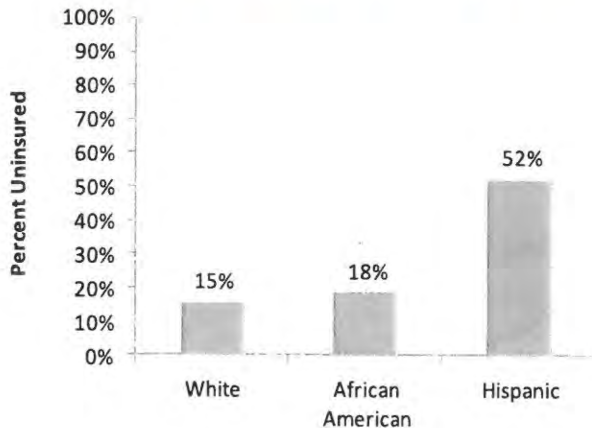
In 2012 there are an estimated 6,082 uninsured children (<18) and an estimated 410 uninsured older adults (>64) in Durham.[10] The proportion of children uninsured is considered "high" (as defined by the North Carolina Institute of Medicine).

Uninsured Status by Age and Residency, 2012[6]



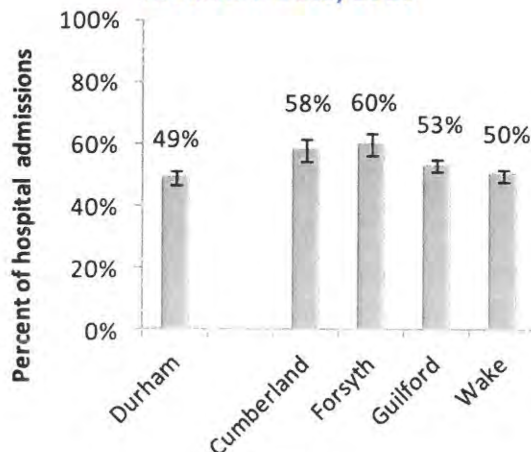
Hispanic Durham County residents are much less likely to have health insurance than White or African American residents. The demographic characteristics of the uninsured population in Durham have remained similar over the past 5 years.

Adults who are Uninsured by Race/Ethnicity, Durham County, 2012[6]



Even for insured residents, health care may be difficult to access. Access to outpatient care is measured by the proportion of hospital visits that would have been prevented by adequate outpatient (ambulatory) care. The best data available come from the Medicare system. The proportion of preventable Medicare hospital stays in Durham County is high, but lower than or comparable to peer counties.

Hospital admissions preventable by outpatient (ambulatory) care Medicare Data, 2010[7]

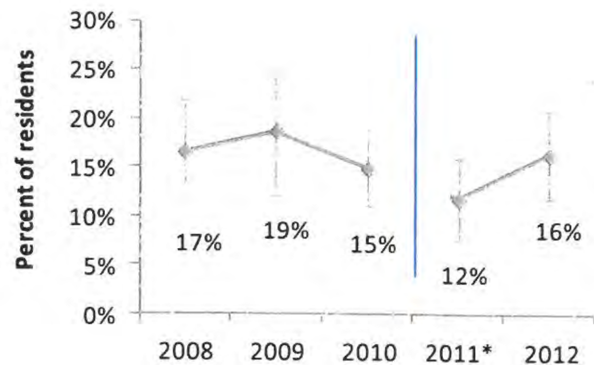


Concerns

- Without Medicaid expansion, an estimated 19,000 adults in Durham County who were anticipated to be covered by Medicaid may remain uninsured. Expected decreases in federal funds for community health centers and hospitals may make it more difficult for uninsured people to access health care.
- County residents with very low income not covered by Medicaid and undocumented immigrants will remain uninsured.

In 2012, 16% of Durham residents reported that they could not see a doctor when needed because of the cost. This is comparable to the North Carolina figure, 19%.

Residents not seeing a doctor because of cost, Durham County[2]



Emerging Issues

- Enrollment in Affordable Care Act Marketplace plans is expected to reduce the number of uninsured adults.
- It is not known whether enough healthcare providers are available to serve the newly insured.

*Because of changes in BRFSS data collection in 2011, data from 2011 and later are not comparable to previous years.

HIV and Other Sexually Transmitted Infections

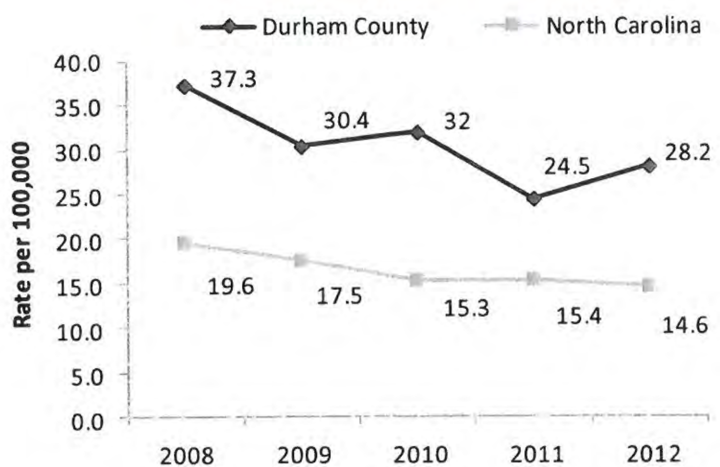
Healthy NC 2020 Goal: Reduce the rate of new HIV infection diagnoses to 22.2 per 100,000

Progress

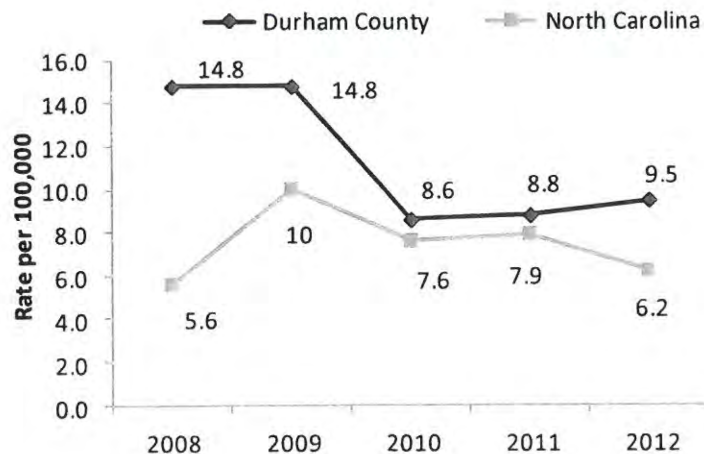
- Testing for HIV and other sexually transmitted infections was offered in many settings, including local universities, Lincoln Community Health Center, the Durham County Jail, and at local collaborating organizations. A national testing day was held at Walgreens locations.
- Expanded hepatitis C screening was offered in many settings where HIV testing was also offered.
- The HIV/STI Committee recognized World AIDS Day with a celebration, speakers, a fashion show, HIV and sexually transmitted disease testing, and communication via the press.
- An article describing the value of syringes retaining less fluid ("low dead-space syringes") for prevention of disease transmission, was published by the HIV/STI Committee in the Durham Herald-Sun. This article followed an article on the same topic published in late 2012 in the Durham News.

Although HIV rates have dropped over the past 5 years, Durham County's rates remain higher than the state average. Syphilis case rates follow a similar pattern.

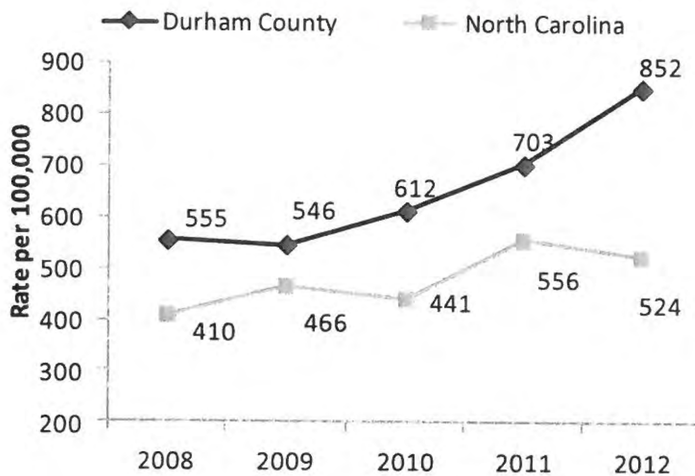
HIV Case Rates, Durham County and North Carolina[8]

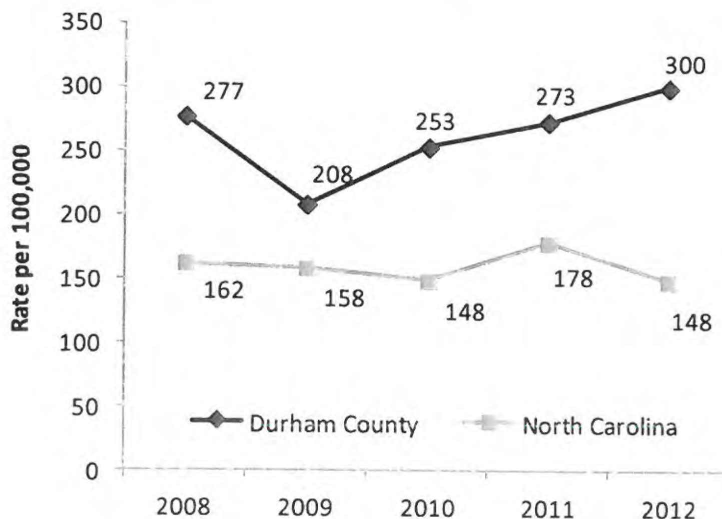


Early Syphilis Case Rates, Durham County and North Carolina[8]



Chlamydia case rates are rising in Durham County. Gonorrhea rates have risen since 2009, but are similar to the 2008 number.





Concerns

- Durham has the 3rd highest rate of HIV cases in North Carolina (up from 4th in 2011).
- Rates of HIV and early syphilis have remained approximately level since 2010, following a decrease prior to 2010.

Emerging Issues

- As providers move to more sensitive nucleic acid testing for chlamydia and gonorrhea, the numbers of cases detected rise. This may account for some of the increase in cases seen. However, the increase may also be due to true increases in prevalence of these diseases.
- With a reduction in staff focusing on syphilis at the state level, syphilis case rates may increase.
- Some strains of gonorrhea are resistant to common antibiotics. These strains may be present in Durham County. Funding for staff focusing on gonorrhea will increase in 2014.

Obesity and Chronic Illness

Healthy NC 2020 Goals:

Increase the percentage of adults getting the recommended amount of physical activity to 60.6%

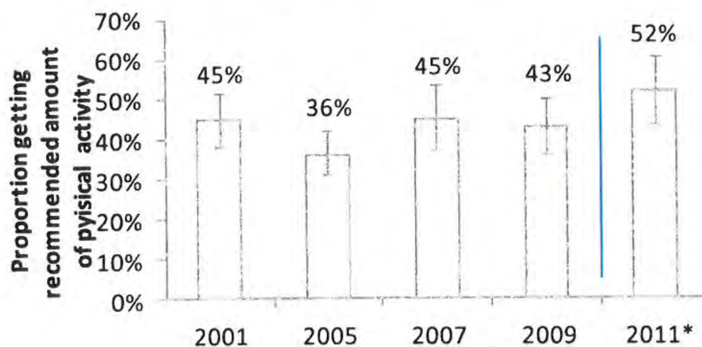
Increase the percentage of adults consuming fruits and vegetables five or more times per day to 29.3%

Decrease the percentage of adults with diabetes to 8.6%; Decrease cardiovascular disease mortality to 161.5

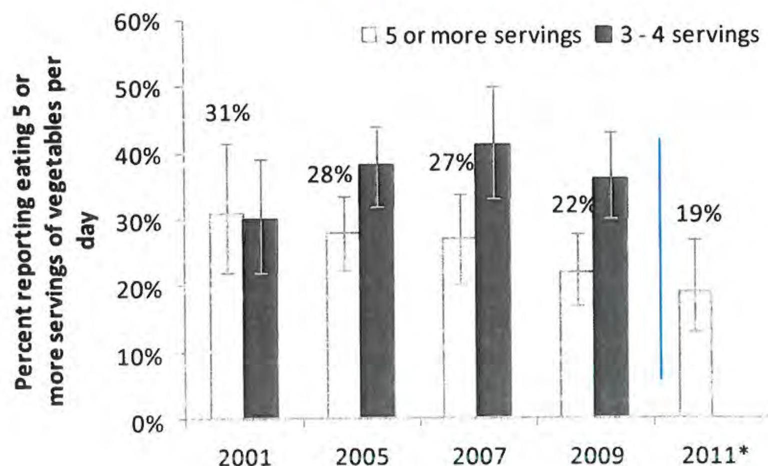
Progress

- Environmental interventions, which change the setting s where people make decisions, make healthy choices easier. A second Healthy Mile Trail was established in North East Central Durham. A third Healthy Mile Trail is in development. A Healthy Check-out Aisle was installed at Los Primos grocery store.
- Five Bull City PlayStreets events were held.
- New questions to create baseline measurements of population walking and biking were included for the 2014 Community Health Assessment.
- ahealthierdurham.com was launched to support physical activity in Durham. It will allow posting of events by many organizations and capture minutes exercised and weight lost by the Durham Community.
- Read about the Durham Diabetes Coalition on page 5.

The proportion of Durham County residents getting the recommended amount of physical activity has increased.



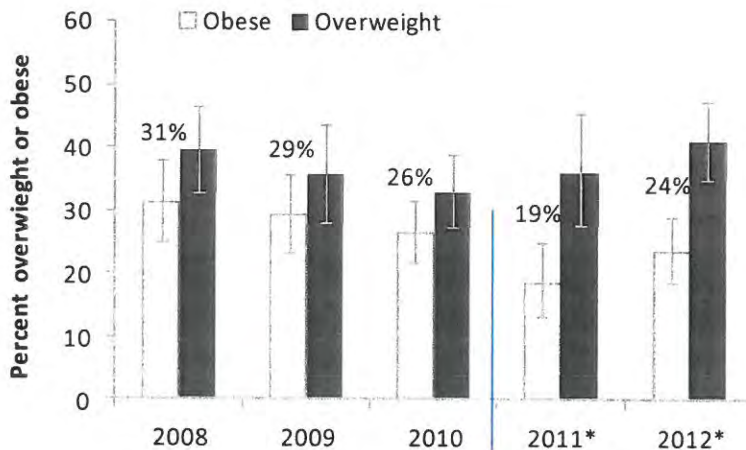
The proportion of Durham County residents eating 5 or more servings per day of fruits and vegetables has decreased. However, the proportion of residents eating 3 or 4 servings per day has remained steady.



*Because of changes in BRFSS data collection in 2011, data from 2011 and later are not comparable to previous years.

The proportion of Durham County residents who are obese has remained level since 2008. The proportion who are overweight (41% in 2012) has also been level since 2008.

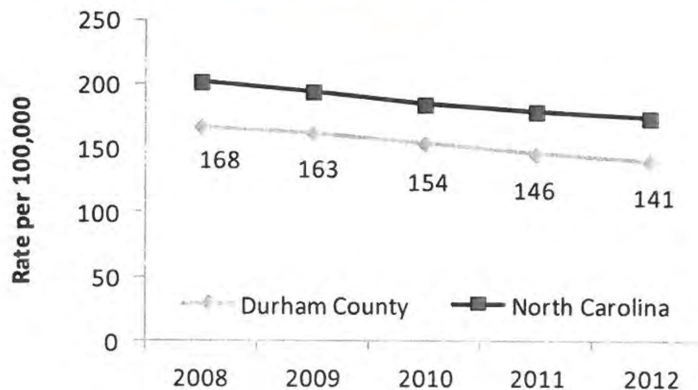
Obese and Overweight Adults, Durham County[2]



The proportion of Durham County residents reporting that they have been diagnosed with cardiovascular disease and diabetes (not during pregnancy) has also been level, at 6-8%, since 2008. This is comparable to the state figure.

However, mortality (death) rates for heart disease and cancer have fallen steadily since 2008 (from 168 per 100,000 to 141 for heart disease, and from 194 to 181 for cancer).

Heart disease mortality rates (age-adjusted, 5 year averages)[3]



Concerns

- Despite local efforts, the proportion of adults who are overweight or obese has not altered significantly over the past 5 years.

Emerging Issues

- Obesity is linked to poverty; people with lower socio-economic status are more likely to be obese.
- The 2011 Community Health Assessment identified a desire for exercise opportunities that are low-cost and located in neighborhoods. Making exercise available locally and cheaply may help reduce obesity in Durham County.

Substance Abuse and Mental Health

Healthy NC 2020 Goals:

Reduce the percentage of high school students who consumed alcohol within the past 30 days to 35%

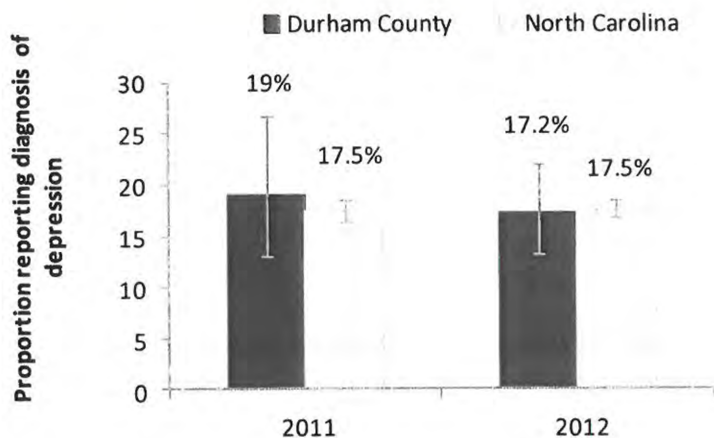
Reduce the suicide rate to 8.3 per 100,000

Progress

- The 2013 Recovery Celebration, coordinated by the Criminal Justice Resource Center, linked recovery from substance addiction and mental illness to exercise, nutrition, and chronic disease prevention. In addition to testimonials and celebratory presentations, the event offered health screenings, healthy cooking demonstrations, and physical activity breaks. Durham TRY and other organizations provided education and tools.
- The Durham Teen Center, Durham Gun Safety Team, and Partnership for a Healthy Durham joined to present a full day suicide prevention and gun safety training to teen youth leaders from across the state at the 2013 North Carolina Teen Summit.
- Efforts to streamline mental health care for children are producing valuable discussion between medical care providers, Durham Public Schools, and other agencies; see more on page 16.

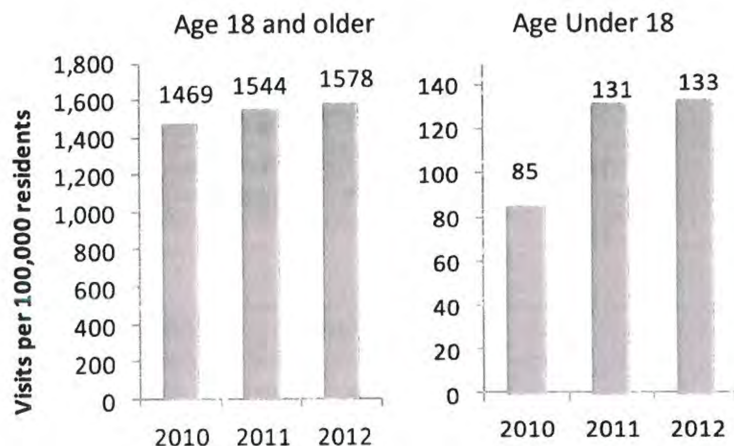
In 2012, 17% of Durham County residents reported that they had been diagnosed with a depressive disorder. This was comparable to the North Carolina figure.

Report of diagnosis with a depressive disorder[2]



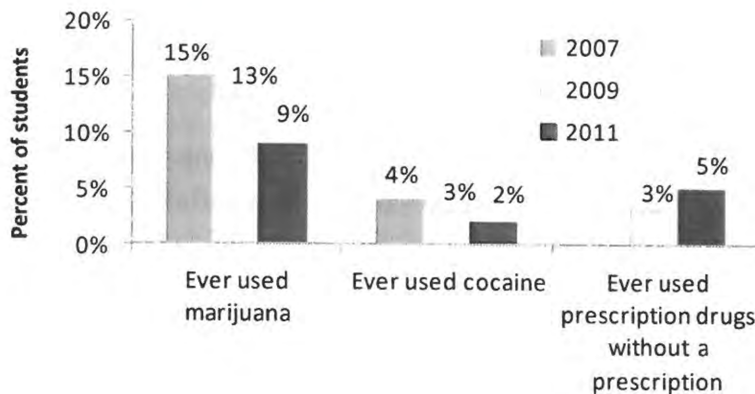
The number of substance use-related visits to the emergency department per 100,000 population appears to be increasing slightly since 2010.

Substance use-related visits to the Emergency Department (source: NC DETECT)[9]

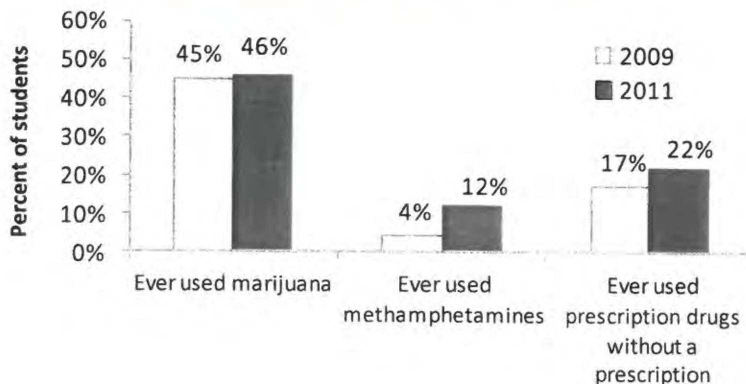


- The proportion of high school students consuming alcohol in the past 30 days was 36% in 2011.
- The proportion of high school students who smoked cigarettes in the past 30 days was 16% in 2011.
- Reported drug use among Durham County youth in middle school is decreasing, with the exception of prescription drug use. Reported drug use among Durham County youth in high school may be increasing.

Reported drug use, Middle School[10]



Reported drug use, High School[10]



- The Durham County age-adjusted suicide rate for 2007-2011 was 8.3 suicides per 100,000 population.

Concerns

- Prescription drug use may be increasing among students.
- Substance use-related visits to the emergency department are increasing.
- State data show that only a small proportion of those needing treatment for mental health and substance abuse receive it. The mental health and substance abuse treatment services available are not adequate to meet the need.

Emerging Issues

- Prescriptions of opioid medications have increased in North Carolina. Emergency department visits for drug overdose are correlated with increased opioid medication sales. Substance abuse-related emergency department visits are increasing in Durham County, and this increase may be related to opioid use.

Poverty

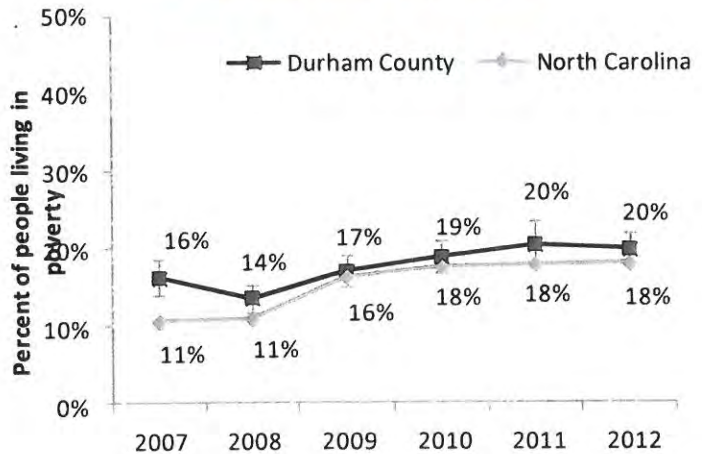
Healthy NC 2020 Goals:
Decrease the percentage of individuals living in poverty to 12.5%
Decrease the percentage of people spending more than 30% of their income on rental housing to 36.1%

Progress

- The Partnership for a Healthy Durham has worked through our Access to Care committee and with End Poverty Durham, and Durham Health Initiatives (DHI) in 2013 to address poverty in Durham.
- End Poverty Durham has created and raised funds in 2013 to implement the REAL Durham Initiative, using evidence-based Circles methods, to lift families out of poverty.
- DHI has created a committee focusing on linking Spanish-speaking county residents with needed services. The Partnership, DHI and community volunteers worked together to add a random sample of Hispanic/Latino community residents to the community health assessment survey performed in 2013.
- The Access to Care Committee created a pilot project to provide short-term medical respite housing for medically vulnerable homeless county residents (called Hospital to Home for the Homeless). In addition to short-term medical respite housing, the project will provide participants with connection to medical and mental health care, nurse care manager services, benefits acquisition and housing planning/ placement.

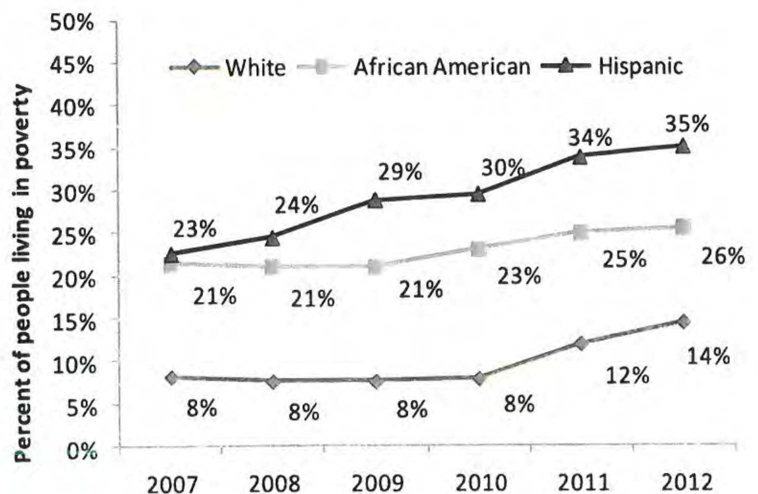
The proportion of Durham County residents living in poverty remains high.

Individuals living in poverty[11]

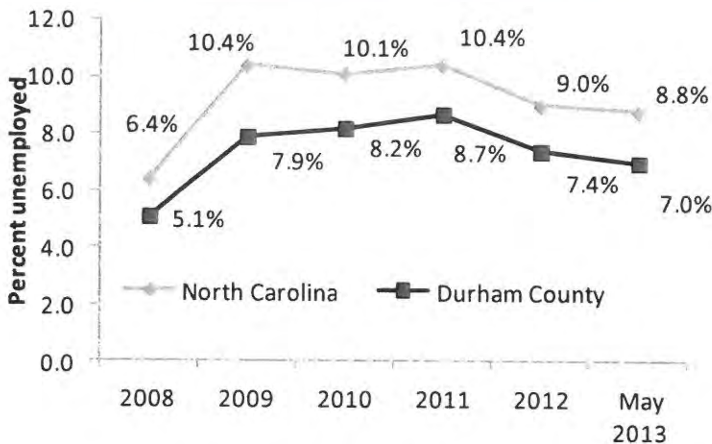


An income below the poverty level is most common among African American and Hispanic/Latino county residents.

Individuals living in poverty by race/ethnicity, Durham County[12]

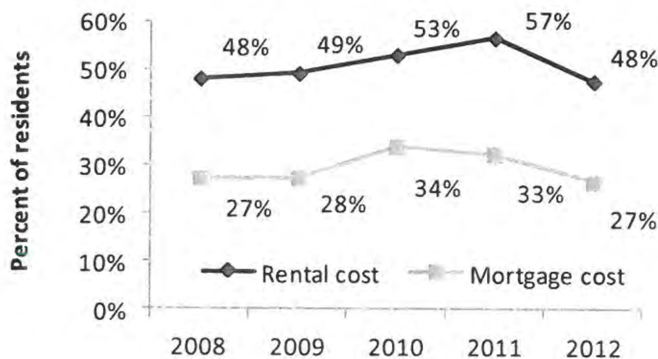


Although the proportion of county residents living in poverty is not decreasing, the Durham County unemployment rate is falling.



People with higher incomes, more years of education, and a healthy and safe environment have better health outcomes.

Housing is considered "affordable" when housing costs are not more than 30% of household income. Half or more of Durham County residents renting their homes are paying more than 30% of their income in rent. Among those who own homes, a smaller percent spends more than 30% of their income on housing (mortgage costs). The proportion spending more than 30% of their income on housing has fallen slightly but is still high.



Concerns

The poverty rate continues to rise

- In 2012 (one-year estimate), 19.8% of Durham County residents lived in poverty.
- 37% of Durham residents have an income below 200% of the Federal Poverty Level

The number of homeless individuals increased in 2013

- 759 individuals were identified as homeless in the 2013 Point in Time count (up from 698 in 2012)

Education

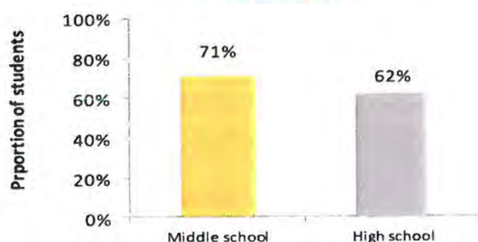
Healthy NC 2020 Goal: Increase the four-year high school graduation rate to 94.6%

Progress

- The graduation rate in Durham continues to improve.
- The Durham Public Schools Family Academy is a collaboration between the schools and community organization and agencies. It offers information about connecting with schools, personal and professional development for families, healthy living, and physical and emotional development.
- Duke Medicine, with collaboration from Durham Public Schools, has created the Integrated Pediatric Mental Health Collaborative. The goal of this collaboration is to improve the integration of pediatric mental health care for children in Durham.

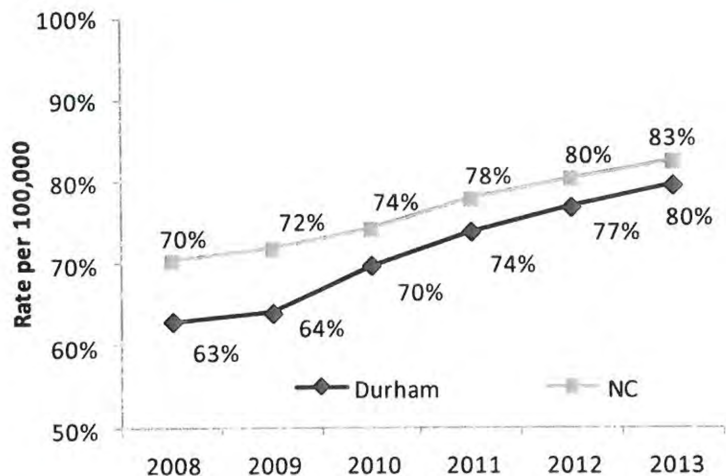
Students in middle and high school report that "their teachers really care about them and give them a lot of encouragement".

Percent of students reporting caring teachers[10]



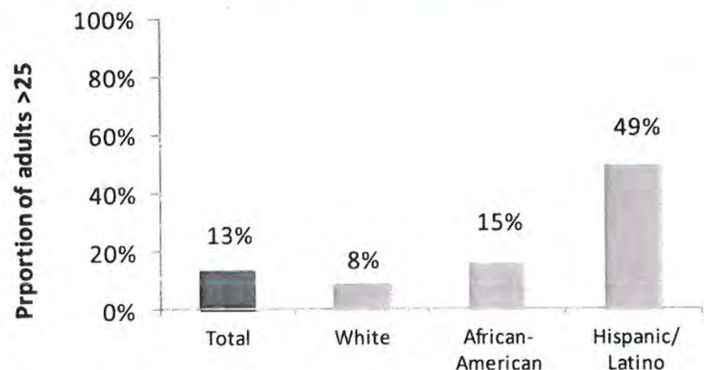
Durham's 4-year graduation rate continues to improve; the gap between Durham and state graduation rates continues to narrow.

High school graduation rates[15]



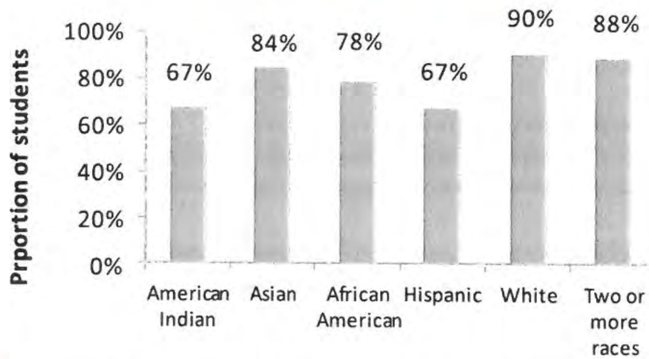
Among adults (>25), 13% have no high school diploma. The proportion with no high school diploma differs by race/ethnicity (below) and by poverty level; lower income is associated with lower educational attainment. It is likely that poverty accounts for much of the difference by race/ethnicity.

Percent of adults with no high school diploma by race/ethnicity, Durham County, 2013[16]



- Graduation rates varied by race, poverty, and English proficiency. Graduation rates for all groups increased in 2013, including for African Americans (from 74% in 2012 to 78% in 2013) and Hispanics (from 64% in 2012 to 67% in 2013.)

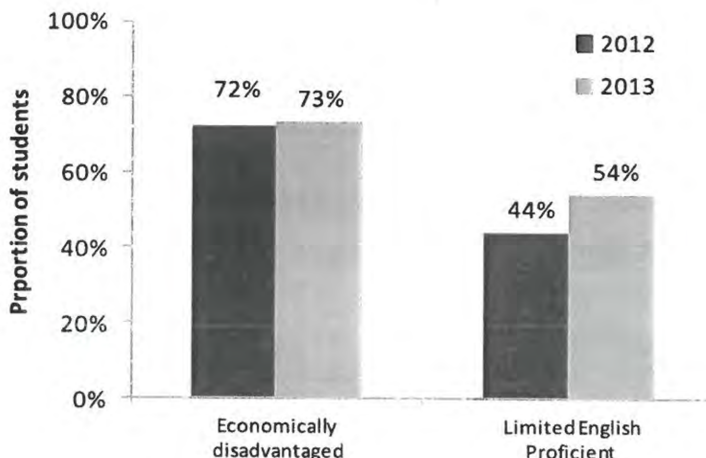
High school graduation rates by race/ethnicity, Durham County, 2013[15]



- Some of the variation in graduation by race/ethnicity is likely to be caused by poverty and language skills. Students from economically disadvantaged backgrounds and those with limited English proficiency were less likely to graduate in 4 years.

- Graduation rates for students with limited English proficiency increased in 2013.

High school graduation rates, Durham County, 2013[15]



Concerns

- Although the graduation rate for students with limited English proficiency have improved in recent years, graduation rates for these students are lower than their Durham counterparts.
- Adult African Americans and Hispanics are least likely to have a high school diploma.

Emerging Issues

- With ongoing immigration in Durham County comes the challenge of ensuring educational attainment for students with limited English proficiency.
- Similarly, providing educational support for adult residents with limited English proficiency is challenging.
- Cuts to education funding may impact Durham County's successful efforts to improve graduation rates.

Data Sources and Notes

- The census category "Hispanic" includes all individuals in the county who identify themselves as Hispanic. This category includes rich and poor, ci and non-citizens, and Spanish-speaking, English-speaking, and bilingual individuals.
- Lines protruding from the top and bottom of bars in charts indicate certainty—we could say that we have 95% certainty that the true measurement lies within the bars. Longer lines mean that we are less certain about the exact number, usually because the survey that gives us the number only sampled a small number of county residents.
- In general, American Community Survey 1-year estimates are provided. In some cases, because of data instability, 3-year estimates are used. This is noted in the data source note.

Photo credits: Cover: Farmer's Market markschuelerphoto.com and Durham Convention and Visitors Bureau; Durham Skyline Downtown, Chris Barron and Durham Convention and Visitors Bureau; Festival for the Eno Durham Convention and Visitors Bureau; Page 3, top: Dan Hacker Photography/Durham Convention and Visitors Bureau; Page 3, bottom: Steward Waller and Durham Convention and Visitors Bureau.

1 US Census Bureau. 2012 American Community Survey 1-Year Estimates, Table DP05: 2012 Demographic and Housing Estimates. American FactFinder. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Accessed November 5, 2013.

2 Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance Survey Results. North Carolina State Center for Health Statistics. http://www.schs.state.nc.us/data/brfss/survey.htm. Accessed November 18, 2013.

3 North Carolina State Center for Health Statistics. 2011 County Health Data Book. http://www.schs.state.nc.us/schs/data/databook/. Accessed November 12, 2013.

4 North Carolina State Center for Health Statistics. HealthStats—Healthy North Carolina 2020 Categorized Index. http://healthstats.publichealth.nc.gov/indicator/index/Categorized.html?CategorizedIndexName=1. Accessed November 10, 2013.

5 Adolescent Pregnancy Prevention Campaign of North Carolina. http://www.appcnc.org/data. Accessed November 12, 2013.

6 US Census Bureau. 2012 American Community Survey 1-Year Estimates, Table S2701: Health Insurance Coverage Status. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Accessed November 3, 2013.

7 University of Wisconsin Population Health Institute. County Health Rankings—Durham County. http://www.countyhealthrankings.org/app#/north-carolina/2013/durham/county/outcomes/overall/snapshot/by-rank. Accessed November 1, 2013.

8 North Carolina Department of Health and Human Services. 2012 HIV/STD Surveillance Report. http://epi.publichealth.nc.gov/cd/stds/figures/std12rpt.pdf. Accessed November 18, 2013.

9 Duke Center for Child and Family Policy. Substance Use and Abuse in Durham County. https://childandfamilypolicy.duke.edu/pdfs/pubpres/2013_Substance_Use_Abuse_Durham_County.pdf. Accessed November 16, 2013.

10 Partnership for a Healthy Durham. 2011 Durham Youth Risk Behavior Survey results. http://www.healthydurham.org/index.php?page=health_recent
Accessed November 15, 2013.

11 US Census Bureau. 2012 American Community Survey 1-Year Estimates. Table DP03, Selected Economic Characteristics. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Accessed November 2, [illegible]3.

12 US Census Bureau. 2012 American Community Survey 3-Year Estimates. Table S1701, Poverty Status in the Past 12 Months. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Accessed November 2, 2013.

13 North Carolina Employment Security Commission. Local Area Unemployment Statistics. http://esesc23.esc.state.nc.us/d4/LausSelection.aspx. Accessed November 20, 2013.

14 US Census Bureau. 2012 American Community Survey 1-Year Estimates. Table DP04, Selected Housing Characteristics. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Accessed November 2, 2013.

15 North Carolina Department of Instruction. Cohort Graduation Rates. http://www.dpi.state.nc.us/accountability/reporting/cohortgradrate. Accessed November 6, 2013.

16 US Census Bureau. 2012 American Community Survey 1-Year Estimates. Table S1501, Educational Attainment. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Accessed November 11, 2013.

The Partnership for a Healthy Durham is a coalition of local agencies and citizens dedicated to collaboratively improving the physical, mental, and social health and well-being of Durham residents. The Partnership links health organizations and citizens concerned with health to develop effective programs and use resources wisely.

Partnership meetings are open to the community and anyone may join at any time either by emailing the coordinator (Erika Samoff, esamoff@dconc.gov) or by coming to a meeting. The full schedule of committee meetings is available under the Calendar link at our website, www.healthydurham.org.

For more detailed information about this report or how the Partnership for a Healthy Durham is addressing these health priorities, go to www.healthydurham.org or contact the Partnership at 919-560-7833.

DURHAM COUNTY
CHILD FATALITY PREVENTION TEAM

Annual Report

January 9, 2014/ Cheryl Scott

Durham County Child Fatality Prevention Team

Objectives:

- To provide a brief history of the North Carolina Child Fatality Review System
- To familiarize members with Durham County Child Fatality Prevention Team (CFPT) goals and program requirements
- To discuss the fatality review process, major themes and actions taken in calendar year 2013

State of North Carolina Child Death Review Legislation

- North Carolina Statute § 7B-1400 (1997)
- Link: http://www.ocme.unc.edu/rules/chp007b.html#CFP

§ 7B-1401. Definitions.

- The following definitions apply in this Article:
- (1) Additional Child Fatality. -- Any death of a child that did not result from suspected abuse or neglect and about which no report of abuse or neglect had been made to the county department of social services within the previous 12 months.

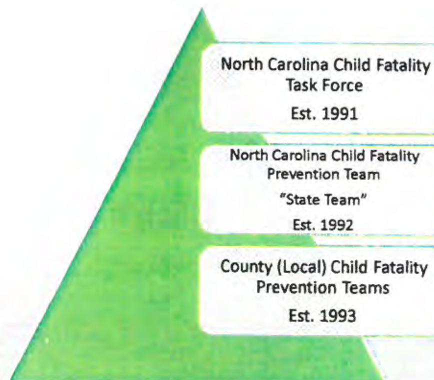
Child Fatality Reviews

- *Do not include fetal deaths*
- *According to State Statute, the CFPT reviews the deaths of children from birth through the age of 17 years. Fetal deaths fall outside of state statute and are not included in the child death count.*

NC Child Fatality Review System Purpose

- Promote understanding of the causes of child deaths
- Identify deficiencies in the service delivery to children and families by public agencies
- To assess, recommend and support the implementation of systems changes that will prevent future child deaths and support the safe and healthy development of our children

North Carolina's Three Tier Child Fatality Prevention System



Who serves on the local CFPT?

- County department of social services
- Local health care providers
- Local law enforcement agency
- Local department of public health
- District attorney's office
- Emergency medical services

Who serves on the local CFPT?

- Community action agency
- District court
- Local schools
- County medical examiner
- County DSS Board
- Local day care
- Local mental health agency
- Parents
- Guardians ad litem

*The board of county commissioners may appoint a maximum of **five additional members** to represent county agencies or the community at large to serve on the local CFPT.*

What is the role of individual CFPT members?

- Attend meetings.
  The General Statute requires teams to meet a minimum of four (4) times annually. (Meetings are not open to the public.)
- Provide any available information from agency records about each child's death.
- Notify the Chair Person and/or the Review Coordinator if unable to attend a meeting or if unable to fulfill CFPT position responsibilities.

What is the role of individual CFPT members?

- Forward information to the Chairperson or Review Coordinator on cases to be reviewed when members are unable to attend.
- Assist in identifying system problems, recommendations and actions.
- Assist to decide if more information is needed to conduct a full child fatality review.

Case Review

- Prior to each meeting, members receive an encrypted email containing:

✓ CFPT Meeting Announcement
✓ List of Cases for Review

- Review Coordinator

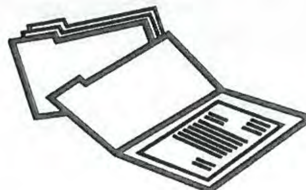
✓ Updates database (Quarterly)
✓ Prepares monthly case updates
✓ Requests medical records if needed

Case Review

✓ Confidentiality Agreement/Attendance Roster

✓ Reviews medical examiner reports, death transcripts, police reports and other records for deceased county residents under age 18 whose fatalities are not due to abuse and neglect.

✓ Members discuss outcomes of services and circumstances surrounding the child's death.



Child Fatality Prevention Team Deaths Reviewed

Age

Zip Codes

27503 Bahama
27712 Durham
27704 Durham
27701 Durham
27703 Durham

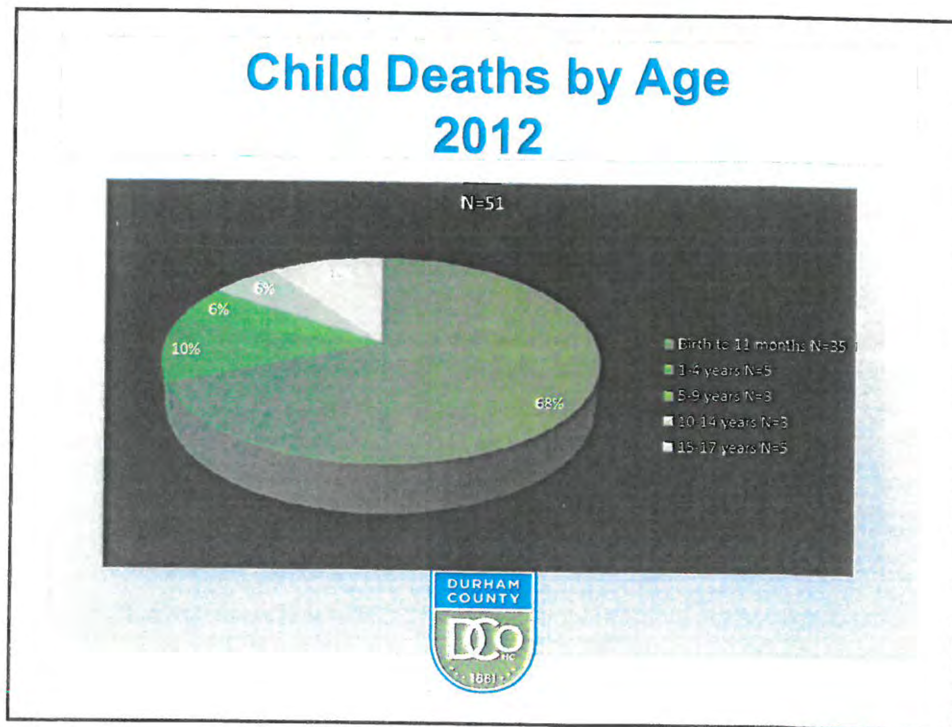
Demographics

Race

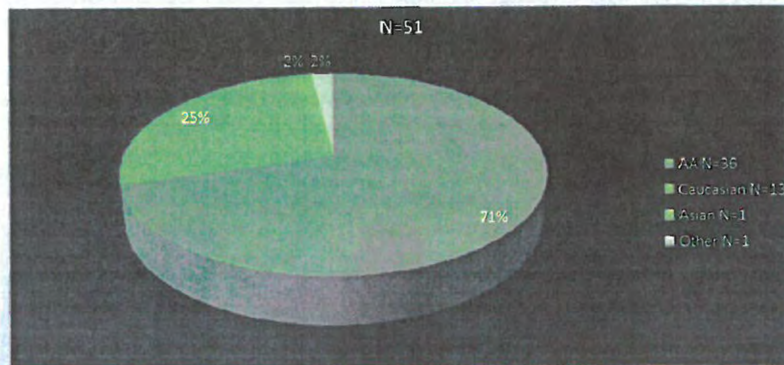
Ethnicity

Sex

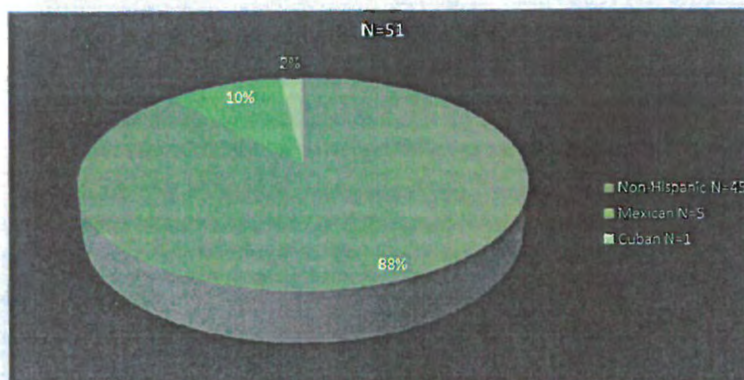
Child Deaths by Age 2012



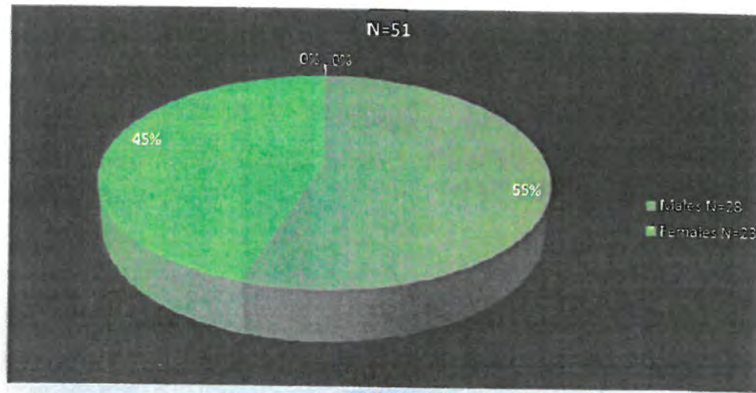
Child Deaths by Race 2012



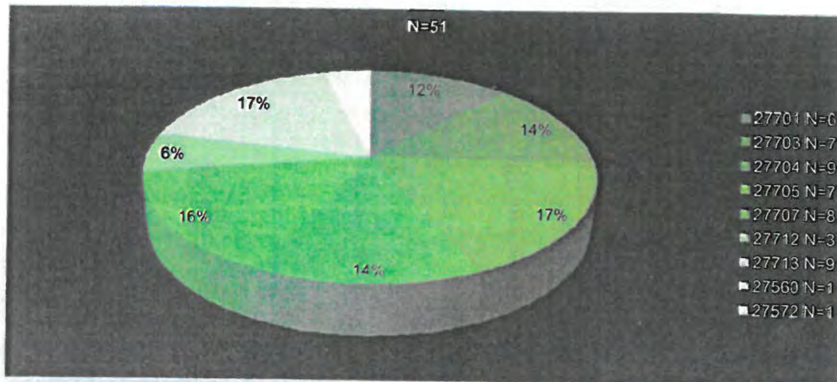
Child Deaths by Ethnicity 2012



Child Deaths by Gender 2012

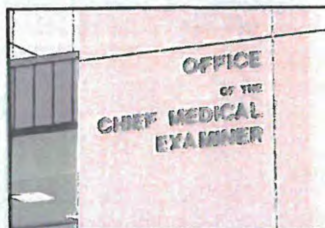


Child Deaths by Zip Codes 2012



Manner of Death

- The fashion or circumstances that result in death, which are designated either natural or unnatural.
- Unnatural deaths are designated as accidental, homicidal, suicidal, or, in absence of a determination based on the balance of probabilities of the manner of death, undetermined.

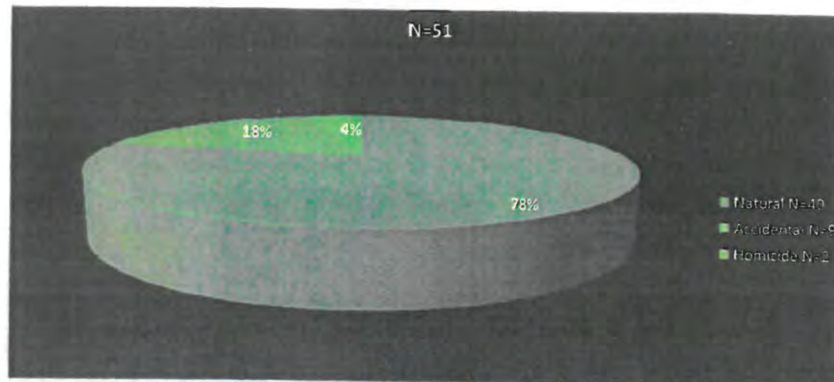


Segen's Medical Dictionary. © 2012 Farlex, Inc.

The majority of child deaths from known natural disease and illness occurred in infancy while deaths in older children were more likely to occur from external causes.

Age	Total Child Deaths	ME/CFPT Child Deaths	% of Total Child Deaths that were ME Cases
Infant	35	2	6%
1-4 years	5	1	20%
5-9 years	3	1	33%
10-14 years	3	2	67%
15-17 years	5	4	80%
Total	51	10	13%

Manner of Death
2012



Manner of Death
Natural

There were ***40*** natural deaths (78% of deaths reviewed):

- Most were in the birth to 11 months age range
- 2 (6% of infant deaths that were ME cases) were SIDS deaths

Other natural causes accounted for ***37*** deaths: (73% of deaths reviewed)
Examples include:

- ✓ Extreme immaturity
- ✓ Anencephaly
- ✓ Placenta Separation
- ✓ Leukemia
- ✓ Respiratory failure of a newborn

Manner of Death Accidental

There were ***9*** accidental deaths and all occurred in children; ages ranged from infant to17 years of age. (18% of deaths reviewed)

Motor Vehicle Accidents (3)
Firearm (3)
Electrocution (1)
Overdose-Opiate (1)
Suffocation (1)

Manner of Death Suicide

No cases reported for 2012

Manner of Death
Undetermined

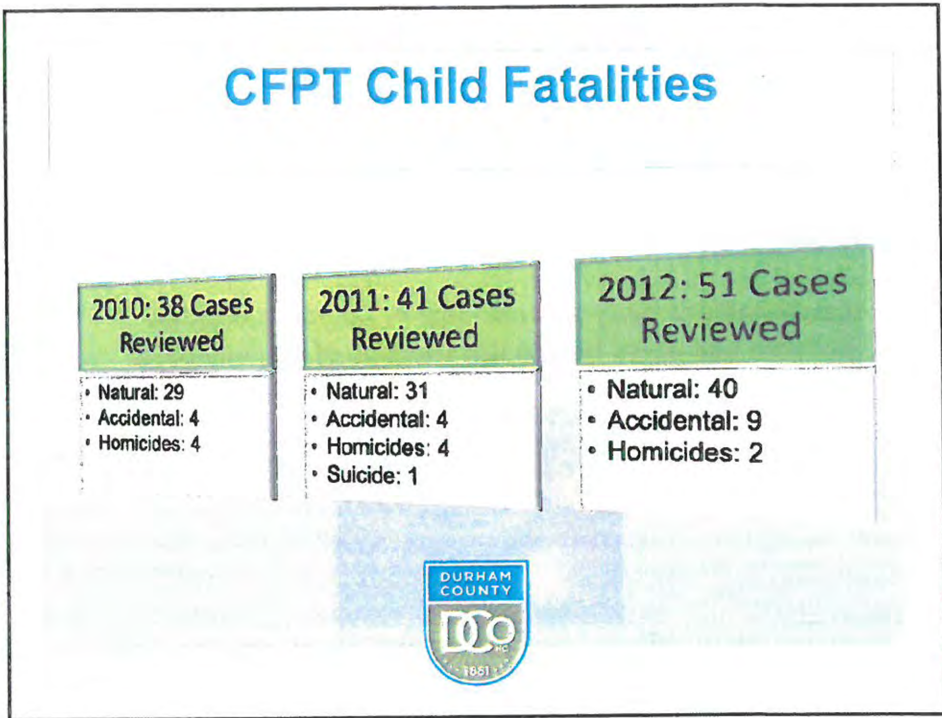
Undetermined: 0 cases with this classification in 2012

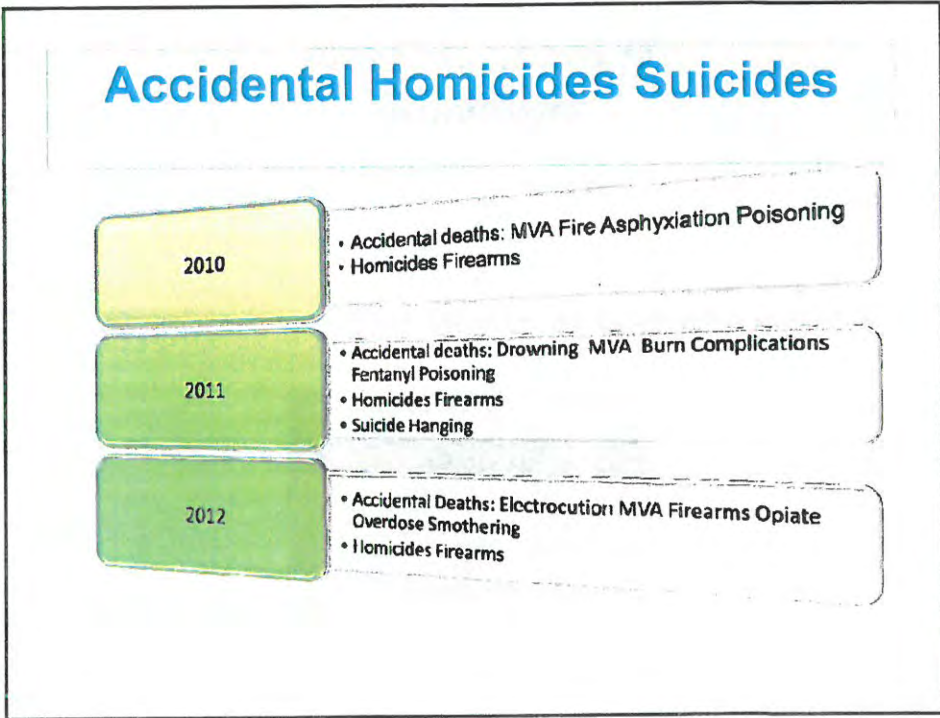
- Intentionality of injury was not clear or no cause could be identified that would lead to identification of the manner of death.

Manner of Death
Homicide

There were ***2*** homicides:

- 17 year old gunshot wound to the head
- 13 year old gunshot wound to the head


CFPT Child Fatalities
2010: 38 Cases Reviewed
• Natural: 29
• Accidental: 4
• Homicides: 4
2011: 41 Cases Reviewed
• Natural: 31
• Accidental: 4
• Homicides: 4
• Suicide: 1
2012: 51 Cases Reviewed
• Natural: 40
• Accidental: 9
• Homicides: 2
DURHAM COUNTY
1881


Accidental Homicides Suicides
2010
• Accidental deaths: MVA Fire Asphyxiation Poisoning
• Homicides Firearms
2011
• Accidental deaths: Drowning MVA Burn Complications Fentanyl Poisoning
• Homicides Firearms
• Suicide Hanging
2012
• Accidental Deaths: Electrocution MVA Firearms Opiate Overdose Smothering
• Homicides Firearms

Recommendations/Actions

No system concerns were identified in 2013 (2012 reviews)

In 2013, the Durham County CFPT:

- Participated in the Annual Child Abuse Walk sponsored by Durham County DSS on April 25, 2013.
- CFPT Chairperson, Karlene Fyffe was interviewed on the county's Channel 8 and discussed Durham County's CFPT.

As the CFPT prepares for 2013 child death reviews...

The team continues to discuss strategies and activities to address risk factors to bring awareness to child fatality in Durham County

Of particular interest...

- Prenatal care
- Firearm safety
- Bicycle/Scooter safety
- Mental Health
- Community Education

Summary

- Provided a brief history of the North Carolina Child Fatality Review System
- Familiarized members with Durham County Child Fatality Prevention Team (CFPT) components/program requirements
- Discussed fatality reviews/major themes and actions taken in calendar year 2013

Thank you for your attention

PUBLIC HEALTH EXPENDITURES AS OF 12/31/2013 10:07 AM

Commitment item	Name	Current Budget	Actuals	% Spent
5100011000	SALARIES AND WAGES--REGULAR	$ 10,473,095.00	$ 4,644,782.54	0.4435
5100012000	SAL & WAGES--TEMP & PART-TIME	$ 751,781.00	$ 195,369.29	0.2599
5100012300	SALARIES AND WAGES--OVERTIME	$ -	$ 2,996.55	X
5100020100	PAY PLAN ADJUSTMENT	$ 148,833.00	$ -	0.0000
5100020500	PHONE ALLOWANCE	$ 15,648.00	$ 5,910.00	0.3777
5100061000	FICA EXPENSE	$ 872,254.00	$ 352,465.85	0.4041
5100061300	RETIREMENT	$ 803,274.00	$ 340,188.01	0.4235
5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 567,988.00	$ 240,585.56	0.4236
PERSONNEL		**$ 13,632,873.00**	**$ 5,782,297.80**	**0.4241**
5200110200	TELEPHONE	$ 42,350.00	$ 10,677.40	0.2521
5200110300	POSTAGE	$ 25,000.00	$ 8,242.30	0.3297
5200110400	PRINTING SUPPLIES	$ 16,868.00	$ 5,438.39	0.3224
5200110500	COST PER COPY FEES	$ 32,000.00	$ 20,336.21	0.6355
5200114300	OFFICE SUPPLIES AND MATERIALS	$ 43,985.00	$ 32,282.42	0.7339
5200130100	TRAINING RELATED TRAVEL	$ 91,869.00	$ 37,237.61	0.4053
5200130300	DUES AND SUBSCRIPTIONS	$ 9,285.00	$ 6,513.84	0.7015
5200140300	M & R EQUIPMENT	$ 75,540.00	$ 13,470.19	0.1783
5200140400	M & R VEHICLES	$ 16,000.00	$ 2,403.14	0.1502
5200150100	OPERATIONAL TRAVEL	$ 61,973.00	$ 10,073.78	0.1626
5200150300	GASOLINE	$ 18,029.00	$ 5,232.95	0.2903
5200150400	FOOD AND PROVISIONS	$ 23,810.00	$ 9,897.66	0.4157
5200151000	SOFTWARE-NONCAPITAL	$ 5,187.00	$ 3,224.82	0.6217
5200152100	PHARMACY SUPPLIES	$ 355,645.00	$ 171,642.23	0.4826
5200152200	LABORATORY SUPPLIES	$ 134,360.00	$ 32,569.61	0.2424
5200153300	ANCILLARY SUPPLIES	$ 85,233.00	$ 26,300.51	0.3086
5200153500	CLIENT INCENTIVES	$ 16,171.00	$ 3,707.97	0.2293
5200154100	IMMUNIZATIONS	$ 48,250.00	$ 44,775.86	0.9280
5200154200	OTHER MEDICAL SUPPLIES	$ 262,557.00	$ 74,863.84	0.2851
5200154300	MEDICAL EXPENSES	$ 5,850.00	$ -	0.0000
5200159500	MISCELLANEOUS SUPPLIES	$ 261,119.82	$ 68,135.38	0.2609
5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 6,089,950.54	$ 2,935,331.94	0.4820

5200169400	CHILD FATALITY PREVENTION	$	-	$	(14.50)	X
5200180100	ADVERTISING	$	1,500.00	$	90.00	0.0600
5200180300	UNIFORMS	$	7,710.00	$	3,405.85	0.4417
5200184000	INSURANCE AND BONDS	$	346,760.00	$	346,760.00	1.0000
5200191000	MISCELLANEOUS EXPENSE	$	160,846.41	$	-	0.0000
5200200000	NON-CAPITAL COMPUTER EQUIP	$	15,373.00	$	3,297.81	0.2145
OPERATING		**$**	**8,253,221.77**	**$**	**3,875,897.21**	**0.4696**
5900300400	RESERVE FOR FUTURE PROJECTS	$	229,007.00	$	-	0.0000
TRANSFERS		**$**	**229,007.00**	**$**	**-**	0.0000
TOTAL EXPENDITURES		**$**	**22,115,101.77**	**$**	**9,658,195.01**	**0.4367**

PUBLIC HEALTH EXPENDITURES BY FUND CENTER AS OF 12/31/2013 10:07 AM

Fund Center	Fund Center Name	Commitment item	CI Name	Current Budget	Actuals	%Spent
5100621100	**PUBLIC HEALTH ADMINISTRATION**	5100011000	SALARIES AND WAGES--REGULAR	$ 1,694,260.00	$ 766,711.52	0.4525
		5100012000	SAL & WAGES--TEMP & PART-TIME	$ 65,930.00	$ 20,502.88	0.3110
		5100012300	SALARIES AND WAGES--OVERTIME	$ -	$ -	X
		5100020100	PAY PLAN ADJUSTMENT	$ 24,898.00	$ -	-
		5100020500	PHONE ALLOWANCE	$ -	$ 1,465.00	X
		5100061000	FICA EXPENSE	$ 136,613.00	$ 55,752.88	0.4081
		5100061300	RETIREMENT	$ 126,151.00	$ 55,248.85	0.4380
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 89,253.00	$ 39,072.98	0.4378
		PERSONNEL		**$ 2,137,105.00**	**$ 938,754.11**	**0.4393**
		5200130100	TRAINING RELATED TRAVEL	$ 12,479.00	$ 8,527.05	0.6833
		5200150100	OPERATIONAL TRAVEL	$ 500.00	$ 25.71	0.0514
		OPERATING		**$ 12,979.00**	**$ 8,552.76**	**0.6590**
		TOTAL		**$ 2,150,084.00**	**$ 947,306.87**	**0.4406**
5100621200	**DEPARTMENTAL**	5100020500	PHONE ALLOWANCE	$ 2,340.00	$ -	-
		PERSONNEL		**$ 2,340.00**	$ -	-
		5200110200	TELEPHONE	$ 16,084.00	$ 2,181.70	0.1356
		5200110300	POSTAGE	$ 25,000.00	$ 8,242.30	0.3297
		5200110500	COST PER COPY FEES	$ 32,000.00	$ 20,336.21	0.6355
		5200114300	OFFICE SUPPLIES AND MATERIALS	$ 31,668.00	$ 27,949.88	0.8826
		5200130100	TRAINING RELATED TRAVEL	$ -	$ 2,108.32	X
		5200130300	DUES AND SUBSCRIPTIONS	$ 3,400.00	$ 4,216.34	1.2401
		5200140400	M & R VEHICLES	$ 16,000.00	$ 2,403.14	0.1502
		5200150300	GASOLINE	$ 18,029.00	$ 5,232.95	0.2903
		5200150400	FOOD AND PROVISIONS	$ 3,000.00	$ 2,665.37	0.8885
		5200151000	SOFTWARE-NONCAPITAL	$ 317.00	$ 317.00	1.0000
		5200159500	MISCELLANEOUS SUPPLIES	$ 15,365.00	$ 6,626.04	0.4312
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 966,838.42	$ 502,781.79	0.5200
		5200180100	ADVERTISING	$ 500.00	$ 90.00	0.1800
		5200180300	UNIFORMS	$ 6,500.00	$ 3,350.85	0.5155
		5200184000	INSURANCE AND BONDS	$ 346,760.00	$ 346,760.00	1.0000
		5200200000	NON-CAPITAL COMPUTER EQUIP	$ 198.00	$ 348.00	1.7576
		OPERATING		**$ 1,481,659.42**	**$ 935,609.89**	**0.6315**

		TOTAL		**$**	**1,483,999.42**	**$**	**935,609.89**	**0.6305**
5100621500	**NUTRITION**	5100011000	SALARIES AND WAGES--REGULAR	$	803,918.00	$	309,936.56	0.3855
		5100012000	SAL & WAGES--TEMP & PART-TIME	$	90,841.00	$	58,780.63	0.6471
		5100012300	SALARIES AND WAGES--OVERTIME	$	-	$	660.04	X
		5100020100	PAY PLAN ADJUSTMENT	$	9,768.00	$	-	-
		5100020500	PHONE ALLOWANCE	$	300.00	$	150.00	0.5000
		5100061000	FICA EXPENSE	$	69,676.00	$	25,781.61	0.3700
		5100061300	RETIREMENT	$	64,820.00	$	25,631.50	0.3954
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	45,530.00	$	18,126.86	0.3981
		PERSONNEL		**$**	**1,084,853.00**	**$**	**439,067.20**	**0.4047**
		5200114300	OFFICE SUPPLIES AND MATERIALS	$	1,000.00	$	-	-
		5200130100	TRAINING RELATED TRAVEL	$	8,938.00	$	2,289.75	0.2562
		5200150100	OPERATIONAL TRAVEL	$	8,344.00	$	2,300.45	0.2757
		5200150400	FOOD AND PROVISIONS	$	9,000.00	$	2,778.67	0.3087
		5200153300	ANCILLARY SUPPLIES	$	75,870.00	$	26,160.51	0.3448
		5200159500	MISCELLANEOUS SUPPLIES	$	16,000.00	$	2,712.49	0.1695
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	4,079.00	$	178.00	0.0436
		5200200000	NON-CAPITAL COMPUTER EQUIP	$	4,242.00	$	-	-
		OPERATING		**$**	**127,473.00**	**$**	**36,419.87**	**0.2857**
		5900300400	RESERVE FOR FUTURE PROJECTS	$	63,139.00	$	-	-
		TRANSFERS		**$**	**63,139.00**	**$**	**-**	-
		TOTAL		**$**	**1,275,465.00**	**$**	**475,487.07**	**0.3728**
5100621600	**HEALTH EDUCATION**	5100011000	SALARIES AND WAGES--REGULAR	$	812,579.00	$	347,921.77	0.4282
		5100020100	PAY PLAN ADJUSTMENT	$	14,139.00	$	-	-
		5100020500	PHONE ALLOWANCE	$	1,440.00	$	420.00	0.2917
		5100061000	FICA EXPENSE	$	63,270.00	$	25,740.95	0.4068
		5100061300	RETIREMENT	$	58,423.00	$	24,598.05	0.4210
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	41,335.00	$	17,396.01	0.4209
		PERSONNEL		**$**	**991,186.00**	**$**	**416,076.78**	**0.4198**
		5200110200	TELEPHONE	$	564.00	$	272.35	0.4829
		5200110400	PRINTING SUPPLIES	$	2,380.00	$	64.00	0.0269

		5200114300	OFFICE SUPPLIES AND MATERIALS	$	404.00	$	380.19	0.9411
		5200130100	TRAINING RELATED TRAVEL	$	8,715.00	$	1,149.18	0.1319
		5200130300	DUES AND SUBSCRIPTIONS	$	1,965.00	$	220.00	0.1120
		5200150100	OPERATIONAL TRAVEL	$	6,268.00	$	1,895.91	0.3025
		5200150400	FOOD AND PROVISIONS	$	4,400.00	$	2,881.45	0.6549
		5200153500	CLIENT INCENTIVES	$	3,507.00	$	2,000.00	0.5703
		5200159500	MISCELLANEOUS SUPPLIES	$	62,514.00	$	30,654.57	0.4904
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	40,869.00	$	4,749.06	0.1162
		OPERATING		**$**	**131,586.00**	**$**	**44,266.71**	**0.3364**
		TOTAL		**$**	**1,122,772.00**	**$**	**460,343.49**	**0.4100**
5100621700	**LABORATORY**	5100011000	SALARIES AND WAGES--REGULAR	$	385,804.00	$	173,854.68	0.4506
		5100020100	PAY PLAN ADJUSTMENT	$	7,147.00	$	-	-
		5100061000	FICA EXPENSE	$	30,071.00	$	12,957.26	0.4309
		5100061300	RETIREMENT	$	27,770.00	$	12,291.45	0.4426
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	19,648.00	$	8,692.94	0.4424
		PERSONNEL		**$**	**470,440.00**	**$**	**207,796.33**	**0.4417**
		5200110200	TELEPHONE	$	90.00	$	90.00	1.0000
		5200130100	TRAINING RELATED TRAVEL	$	250.00	$	-	-
		5200140300	M & R EQUIPMENT	$	50,000.00	$	12,900.00	0.2580
		5200150100	OPERATIONAL TRAVEL	$	250.00	$	-	-
		5200152200	LABORATORY SUPPLIES	$	124,910.00	$	30,568.11	0.2447
		5200153300	ANCILLARY SUPPLIES	$	7,400.00	$	-	-
		5200159500	MISCELLANEOUS SUPPLIES	$	72,816.00	$	14,012.71	0.1924
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	27,912.00	$	6,619.54	0.2372
		OPERATING		**$**	**283,628.00**	**$**	**64,190.36**	**0.2263**
		TOTAL		**$**	**754,068.00**	**$**	**271,986.69**	**0.3607**
5100621800	**DENTAL**	5100011000	SALARIES AND WAGES--REGULAR	$	569,478.00	$	248,755.00	0.4368
		5100020100	PAY PLAN ADJUSTMENT	$	6,413.00	$	-	-
		5100020500	PHONE ALLOWANCE	$	840.00	$	210.00	0.2500
		5100061000	FICA EXPENSE	$	44,075.00	$	16,189.42	0.3673
		5100061300	RETIREMENT	$	40,698.00	$	17,587.00	0.4321
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	28,794.00	$	12,437.85	0.4320
		PERSONNEL		**$**	**690,298.00**	**$**	**295,179.27**	**0.4276**

Program	Name	Account	Description		Budget		Expended	Percent
		5200110200	TELEPHONE	$	972.00	$	365.38	0.3759
		5200110400	PRINTING SUPPLIES	$	1,500.00	$	1,552.00	1.0347
		5200130100	TRAINING RELATED TRAVEL	$	3,875.00	$	1,353.90	0.3494
		5200130300	DUES AND SUBSCRIPTIONS	$	2,200.00	$	1,109.00	0.5041
		5200140300	M & R EQUIPMENT	$	7,700.00	$	570.19	0.0741
		5200150100	OPERATIONAL TRAVEL	$	2,800.00	$	266.55	0.0952
		5200150400	FOOD AND PROVISIONS	$	500.00	$	179.81	0.3596
		5200153500	CLIENT INCENTIVES	$	500.00	$	-	-
		5200154200	OTHER MEDICAL SUPPLIES	$	67,325.00	$	25,081.17	0.3725
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	224,075.00	$	91,286.75	0.4074
		OPERATING		**$**	**311,447.00**	**$**	**121,764.75**	**0.3910**
		TOTAL		**$**	**1,001,745.00**	**$**	**416,944.02**	**0.4162**
5100622100	**GENERAL HEALTH**	5100011000	SALARIES AND WAGES--REGULAR	$	370,382.00	$	162,527.63	0.4388
		5100020100	PAY PLAN ADJUSTMENT	$	8,791.00	$	-	-
		5100020500	PHONE ALLOWANCE	$	300.00	$	-	-
		5100061000	FICA EXPENSE	$	29,019.00	$	11,915.31	0.4106
		5100061300	RETIREMENT	$	26,796.00	$	11,490.69	0.4288
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	18,959.00	$	8,126.42	0.4286
		PERSONNEL		**$**	**454,247.00**	**$**	**194,060.05**	**0.4272**
		5200110200	TELEPHONE	$	860.00	$	343.52	0.3994
		5200110400	PRINTING SUPPLIES	$	2,800.00	$	45.00	0.0161
		5200114300	OFFICE SUPPLIES AND MATERIALS	$	800.00	$	202.89	0.2536
		5200130100	TRAINING RELATED TRAVEL	$	2,590.00	$	984.82	0.3802
		5200150100	OPERATIONAL TRAVEL	$	700.00	$	-	-
		5200150400	FOOD AND PROVISIONS	$	500.00	$	-	-
		5200154200	OTHER MEDICAL SUPPLIES	$	6,600.00	$	5,596.95	0.8480
		5200159500	MISCELLANEOUS SUPPLIES	$	11,550.00	$	1,551.92	0.1344
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	440,841.88	$	202,836.30	0.4601
		OPERATING		**$**	**467,241.88**	**$**	**211,561.40**	**0.4528**
		TOTAL		**$**	**921,488.88**	**$**	**405,621.45**	**0.4402**
5100622200	**IMMUNIZATION**	5100011000	SALARIES AND WAGES--REGULAR	$	214,921.00	$	96,706.27	0.4500
		5100020100	PAY PLAN ADJUSTMENT	$	3,028.00	$	-	-

		5100061000	FICA EXPENSE	$ 16,680.00	$ 7,120.09	0.4269
		5100061300	RETIREMENT	$ 15,402.00	$ 6,837.18	0.4439
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 10,897.00	$ 4,835.24	0.4437
		PERSONNEL		**$ 260,928.00**	**$ 115,498.78**	**0.4426**
		5200110400	PRINTING SUPPLIES	$ 2,600.00	$ 2,065.00	0.7942
		5200130100	TRAINING RELATED TRAVEL	$ 1,050.00	$ 924.81	0.8808
		5200150100	OPERATIONAL TRAVEL	$ 120.00	$ -	-
		5200153300	ANCILLARY SUPPLIES	$ 1,963.00	$ 140.00	0.0713
		5200154100	IMMUNIZATIONS	$ 48,250.00	$ 44,775.86	0.9280
		5200154200	OTHER MEDICAL SUPPLIES	$ 3,100.00	$ 1,052.60	0.3395
		5200159500	MISCELLANEOUS SUPPLIES	$ 3,500.00	$ 648.32	0.1852
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 4,500.00	$ 2,823.00	0.6273
		OPERATING		**$ 65,083.00**	**$ 52,429.59**	**0.8056**
		TOTAL		**$ 326,011.00**	**$ 167,928.37**	**0.5151**
5100622300	**TUBERCULOSIS SCREENING**	5100011000	SALARIES AND WAGES--REGULAR	$ 372,257.00	$ 194,183.96	0.5216
		5100020100	PAY PLAN ADJUSTMENT	$ 1,125.00	$ -	-
		5100020500	PHONE ALLOWANCE	$ 1,800.00	$ 900.00	0.5000
		5100061000	FICA EXPENSE	$ 28,573.00	$ 14,362.08	0.5026
		5100061300	RETIREMENT	$ 26,391.00	$ 13,728.84	0.5202
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 18,668.00	$ 9,709.07	0.5201
		PERSONNEL		**$ 448,814.00**	**$ 232,883.95**	**0.5189**
		5200110200	TELEPHONE	$ 400.00	$ 220.00	0.5500
		5200130100	TRAINING RELATED TRAVEL	$ 1,560.00	$ 277.15	0.1777
		5200150100	OPERATIONAL TRAVEL	$ 1,000.00	$ 445.57	0.4456
		5200154200	OTHER MEDICAL SUPPLIES	$ 2,900.00	$ -	-
		5200154300	MEDICAL EXPENSES	$ 5,850.00	$ -	-
		5200159500	MISCELLANEOUS SUPPLIES	$ 14,273.00	$ 553.83	0.0388
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 39,374.00	$ 13,507.00	0.3430
		OPERATING		**$ 65,357.00**	**$ 15,003.55**	**0.2296**
		TOTAL		**$ 514,171.00**	**$ 247,887.50**	**0.4821**
5100622400	**PHARMACY**	5100011000	SALARIES AND WAGES--REGULAR	$ 217,655.00	$ 106,043.92	0.4872
		5100012000	SAL & WAGES--TEMP & PART-TIME	$ 37,751.00	$ 18,405.00	0.4875

		5100020100	PAY PLAN ADJUSTMENT	$ 3,985.00	$ -	-
		5100061000	FICA EXPENSE	$ 19,852.00	$ 9,037.97	0.4553
		5100061300	RETIREMENT	$ 15,632.00	$ 7,497.35	0.4796
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 11,061.00	$ 5,302.16	0.4794
		PERSONNEL		**$ 305,936.00**	**$ 146,286.40**	0.4782
		5200130100	TRAINING RELATED TRAVEL	$ 1,000.00	$ 104.00	0.1040
		5200130300	DUES AND SUBSCRIPTIONS	$ 120.00	$ -	-
		5200140300	M & R EQUIPMENT	$ 16,340.00	$ -	-
		5200152100	PHARMACY SUPPLIES	$ 355,645.00	$ 171,642.23	0.4826
		5200154200	OTHER MEDICAL SUPPLIES	$ 2,000.00	$ -	-
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 10,000.00	$ 712.56	0.0713
		OPERATING		**$ 385,105.00**	**$ 172,458.79**	**0.4478**
		TOTAL		**$ 691,041.00**	**$ 318,745.19**	**0.4613**
5100622500	**FAMILY PLANNING**	5100011000	SALARIES AND WAGES--REGULAR	$ 503,313.00	$ 239,900.48	0.4766
		5100012000	SAL & WAGES--TEMP & PART-TIME	$ 127,658.00	$ 18,258.75	0.1430
		5100012300	SALARIES AND WAGES--OVERTIME	$ -	$ 33.92	X
		5100020100	PAY PLAN ADJUSTMENT	$ 9,456.00	$ -	-
		5100061000	FICA EXPENSE	$ 49,004.00	$ 19,541.71	0.3988
		5100061300	RETIREMENT	$ 45,261.00	$ 18,254.24	0.4033
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 32,026.00	$ 12,909.63	0.4031
		PERSONNEL		**$ 766,718.00**	**$ 308,898.73**	**0.4029**
		5200114300	OFFICE SUPPLIES AND MATERIALS	$ 800.00	$ 255.34	0.3192
		5200130100	TRAINING RELATED TRAVEL	$ 4,630.00	$ 2,438.18	0.5266
		5200154200	OTHER MEDICAL SUPPLIES	$ 103,000.00	$ 18,529.50	0.1799
		5200159500	MISCELLANEOUS SUPPLIES	$ 3,290.00	$ 550.88	0.1674
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 9,200.00	$ 3,884.00	0.4222
		OPERATING		**$ 120,920.00**	**$ 25,657.90**	**0.2122**
		TOTAL		**$ 887,638.00**	**$ 334,556.63**	**0.3769**
5100622600	**ADULT HEALTH**	5200130100	TRAINING RELATED TRAVEL	$ 410.00	$ -	-
		5200159500	MISCELLANEOUS SUPPLIES	$ 7,271.00	$ 697.23	0.0959
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 21,440.00	$ 10,782.48	0.5029
		OPERATING		**$ 29,121.00**	**$ 11,479.71**	**0.3942**

		TOTAL		**$**	**29,121.00**	**$**	**11,479.71**	**0.3942**
5100622700	**AIDS CONTROL**	5100011000	SALARIES AND WAGES--REGULAR	$	150,138.00	$	73,646.86	0.4905
		5100020100	PAY PLAN ADJUSTMENT	$	1,223.00	$	-	-
		5100061000	FICA EXPENSE	$	11,584.00	$	5,599.16	0.4834
		5100061300	RETIREMENT	$	10,697.00	$	5,206.86	0.4868
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	7,568.00	$	3,682.36	0.4866
		PERSONNEL		**$**	**181,210.00**	**$**	**88,135.24**	**0.4864**
		5200110200	TELEPHONE	$	755.00	$	-	-
		5200114300	OFFICE SUPPLIES AND MATERIALS	$	1,188.00	$	57.99	0.0488
		5200130100	TRAINING RELATED TRAVEL	$	2,180.00	$	-	-
		5200150100	OPERATIONAL TRAVEL	$	1,282.00	$	98.26	0.0766
		5200153500	CLIENT INCENTIVES	$	4,020.00	$	120.00	0.0299
		5200154200	OTHER MEDICAL SUPPLIES	$	8,945.00	$	4,277.17	0.4782
		5200159500	MISCELLANEOUS SUPPLIES	$	550.00	$	-	-
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	151,526.00	$	381.42	0.0025
		OPERATING		$	170,446.00	$	4,934.84	0.0290
		TOTAL		**$**	**351,656.00**	**$**	**93,070.08**	**0.2647**
5100622900	**DIABETES COALITION PROJECT**	5100011000	SALARIES AND WAGES--REGULAR	$	655,729.00	$	261,340.46	0.3985
		5100012300	SALARIES AND WAGES--OVERTIME	$	-	$	492.43	X
		5100020100	PAY PLAN ADJUSTMENT	$	5,270.00	$	-	-
		5100061000	FICA EXPENSE	$	50,580.00	$	19,703.24	0.3895
		5100061300	RETIREMENT	$	46,718.00	$	18,511.64	0.3962
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	33,050.00	$	13,091.69	0.3961
		PERSONNEL		**$**	**791,347.00**	**$**	**313,139.46**	**0.3957**
		5200110200	TELEPHONE	$	9,000.00	$	3,517.23	0.3908
		5200110400	PRINTING SUPPLIES	$	3,000.00	$	1,521.60	0.5072
		5200114300	OFFICE SUPPLIES AND MATERIALS	$	1,000.00	$	843.87	0.8439
		5200130100	TRAINING RELATED TRAVEL	$	8,300.00	$	6,559.12	0.7903
		5200150100	OPERATIONAL TRAVEL	$	11,100.00	$	1,647.16	0.1484
		5200150400	FOOD AND PROVISIONS	$	1,500.00	$	642.95	0.4286

		5200151000	SOFTWARE-NONCAPITAL	$	1,150.00	$	1,137.82	0.9894
		5200153500	CLIENT INCENTIVES	$	1,500.00	$	1,587.97	1.0586
		5200154200	OTHER MEDICAL SUPPLIES	$	1,037.00	$	377.84	0.3644
		5200159500	MISCELLANEOUS SUPPLIES	$	8,987.00	$	7,336.54	0.8164
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	104,000.00	$	6,300.00	0.0606
		5200180100	ADVERTISING	$	1,000.00	$	-	-
		5200200000	NON-CAPITAL COMPUTER EQUIP	$	2,700.00	$	2,610.05	0.9667
		OPERATING		**$**	**154,274.00**	**$**	**34,082.15**	**0.2209**
		5900300400	RESERVE FOR FUTURE PROJECTS	$	165,868.00	$	-	-
		TRANSFERS		**$**	**165,868.00**	**$**	**-**	-
		TOTAL		**$**	**1,111,489.00**	**$**	**347,221.61**	**0.3124**
5100623100	**GENERAL NURSING**	5100011000	SALARIES AND WAGES--REGULAR	$	121,090.00	$	59,059.22	0.4877
		5100020100	PAY PLAN ADJUSTMENT	$	2,127.00	$	-	-
		5100020500	PHONE ALLOWANCE	$	900.00	$	270.00	0.3000
		5100061000	FICA EXPENSE	$	9,430.00	$	4,194.72	0.4448
		5100061300	RETIREMENT	$	8,707.00	$	4,175.50	0.4796
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	6,161.00	$	2,952.94	0.4793
		PERSONNEL		**$**	**148,415.00**	**$**	**70,652.38**	0.4760
		5200114300	OFFICE SUPPLIES AND MATERIALS	$	321.00	$	164.60	0.5128
		5200130100	TRAINING RELATED TRAVEL	$	2,270.00	$	1,966.53	0.8663
		5200150100	OPERATIONAL TRAVEL	$	100.00	$	3.00	0.0300
		5200150400	FOOD AND PROVISIONS	$	500.00	$	213.97	0.4279
		5200159500	MISCELLANEOUS SUPPLIES	$	400.00	$	88.49	0.2212
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	200.00	$	-	-
		OPERATING		**$**	**3,791.00**	**$**	**2,436.59**	**0.6427**
		TOTAL		**$**	**152,206.00**	**$**	**73,088.97**	**0.4802**
5100623200	**MATERNAL HEALTH**	5100011000	SALARIES AND WAGES--REGULAR	$	638,814.00	$	255,136.22	0.3994
		5100012300	SALARIES AND WAGES--OVERTIME	$	-	$	1,263.89	X
		5100020100	PAY PLAN ADJUSTMENT	$	8,613.00	$	-	-
		5100061000	FICA EXPENSE	$	49,551.00	$	18,702.05	0.3774
		5100061300	RETIREMENT	$	45,751.00	$	18,115.83	0.3960
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	32,373.00	$	12,811.73	0.3958

Department	Name	Account	Description		Budget		Actual	Ratio
		PERSONNEL		**$**	**775,102.00**	**$**	**306,029.72**	**0.3948**
		5200110400	PRINTING SUPPLIES	$	800.00	$	89.75	0.1122
		5200114300	OFFICE SUPPLIES AND MATERIALS	$	-	$	111.41	X
		5200130100	TRAINING RELATED TRAVEL	$	5,510.00	$	369.00	0.0670
		5200130300	DUES AND SUBSCRIPTIONS	$	500.00	$	-	-
		5200150400	FOOD AND PROVISIONS	$	2,200.00	$	535.44	0.2434
		5200153500	CLIENT INCENTIVES	$	3,644.00	$	-	-
		5200154200	OTHER MEDICAL SUPPLIES	$	61,400.00	$	19,032.37	0.3100
		5200159500	MISCELLANEOUS SUPPLIES	$	1,500.00	$	149.14	0.0994
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	270,640.25	$	154,660.71	0.5715
		OPERATING		**$**	**346,194.25**	**$**	**174,947.82**	**0.5053**
		TOTAL		**$**	**1,121,296.25**	**$**	**480,977.54**	**0.4289**
5100623300	**CHILD HEALTH**	5100011000	SALARIES AND WAGES--REGULAR	$	456,810.00	$	230,678.28	0.5050
		5100012000	SAL & WAGES--TEMP & PART-TIME	$	39,416.00	$	19,133.35	0.4854
		5100020100	PAY PLAN ADJUSTMENT	$	7,741.00	$	-	-
		5100061000	FICA EXPENSE	$	38,567.00	$	18,607.73	0.4825
		5100061300	RETIREMENT	$	35,615.00	$	17,661.70	0.4959
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	25,198.00	$	12,490.55	0.4957
		PERSONNEL		**$**	**603,347.00**	**$**	**298,571.61**	0.4949
		5200110200	TELEPHONE	$	4,800.00	$	1,029.80	0.2145
		5200110400	PRINTING SUPPLIES	$	300.00	$	-	-
		5200130100	TRAINING RELATED TRAVEL	$	3,590.00	$	595.00	0.1657
		5200150100	OPERATIONAL TRAVEL	$	10,000.00	$	1,041.07	0.1041
		5200159500	MISCELLANEOUS SUPPLIES	$	3,320.00	$	287.00	0.0864
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	54,293.00	$	31,233.18	0.5753
		5200169400	CHILD FATALITY PREVENTION	$	-	$	(14.50)	X
		5200191000	MISCELLANEOUS EXPENSE	$	83,008.36	$	-	-
		OPERATING		**$**	**159,311.36**	**$**	**34,171.55**	**0.2145**
		TOTAL		**$**	**762,658.36**	**$**	**332,743.16**	**0.4363**
5100623500	**JAIL**	5200160100	MISCELLANEOUS CONTRACTED SERVI	$	3,223,848.00	$	1,777,314.17	0.5513
		OPERATING		**$**	**3,223,848.00**	**$**	**1,777,314.17**	**0.5513**

Org	Name	Account	Description	Budget	Actual	Ratio
		TOTAL		**$ 3,223,848.00**	**$ 1,777,314.17**	**0.5513**
5100623600	**SCHOOL HEALTH**	5100011000	SALARIES AND WAGES--REGULAR	$ 898,596.00	$ 454,687.19	0.5060
		5100012000	SAL & WAGES--TEMP & PART-TIME	$ 390,185.00	$ 60,288.68	0.1545
		5100020100	PAY PLAN ADJUSTMENT	$ 14,856.00	$ -	-
		5100020500	PHONE ALLOWANCE	$ 2,388.00	$ 570.00	0.2387
		5100061000	FICA EXPENSE	$ 99,761.00	$ 38,092.35	0.3818
		5100061300	RETIREMENT	$ 92,138.00	$ 36,408.86	0.3952
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 65,181.00	$ 25,748.85	0.3950
		PERSONNEL		**$ 1,563,105.00**	**$ 615,795.93**	0.3940
		5200110200	TELEPHONE	$ 2,138.00	$ 477.12	0.2232
		5200110400	PRINTING SUPPLIES	$ 300.00	$ 69.04	0.2301
		5200130100	TRAINING RELATED TRAVEL	$ 11,890.00	$ 4,492.42	0.3778
		5200150100	OPERATIONAL TRAVEL	$ 4,613.00	$ 1,750.06	0.3794
		5200150400	FOOD AND PROVISIONS	$ 250.00	$ -	-
		5200154200	OTHER MEDICAL SUPPLIES	$ 3,750.00	$ 57.10	0.0152
		5200159500	MISCELLANEOUS SUPPLIES	$ 1,610.00	$ 437.75	0.2719
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 500.00	$ 42.00	0.0840
		5200200000	NON-CAPITAL COMPUTER EQUIP	$ 340.00	$ 339.76	0.9993
		OPERATING		**$ 25,391.00**	**$ 7,665.25**	**0.3019**
		TOTAL		**$ 1,588,496.00**	**$ 623,461.18**	**0.3925**
5100623800	**DURHAM CONNECTS**	5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 306,702.00	$ 124,999.98	0.4076
		OPERATING		$ 306,702.00	$ 124,999.98	0.4076
		TOTAL		**$ 306,702.00**	**$ 124,999.98**	**0.4076**
5100623900	**BABY LOVE PROGRAM**	5100011000	SALARIES AND WAGES--REGULAR	$ 409,264.00	$ 193,327.78	0.4724
		5100020100	PAY PLAN ADJUSTMENT	$ 7,283.00	$ -	-
		5100020500	PHONE ALLOWANCE	$ 2,400.00	$ 1,150.00	0.4792
		5100061000	FICA EXPENSE	$ 31,879.00	$ 14,169.95	0.4445
		5100061300	RETIREMENT	$ 29,437.00	$ 13,668.32	0.4643
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 20,827.00	$ 9,666.33	0.4641
		PERSONNEL		**$ 501,090.00**	**$ 231,982.38**	0.4630

		5200110400	PRINTING SUPPLIES	$ 300.00	$ 32.00	0.1067
		5200114300	OFFICE SUPPLIES AND MATERIALS	$ 1,000.00	$ 108.33	0.1083
		5200130100	TRAINING RELATED TRAVEL	$ 3,440.00	$ 775.72	0.2255
		5200150100	OPERATIONAL TRAVEL	$ 4,496.00	$ 292.94	0.0652
		5200159500	MISCELLANEOUS SUPPLIES	$ 300.00	$ -	-
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 7,830.99	$ 240.00	0.0306
		5200191000	MISCELLANEOUS EXPENSE	$ 77,838.05	$ -	-
		OPERATING		**$ 95,205.04**	**$ 1,448.99**	**0.0152**
		TOTAL		**$ 596,295.04**	**$ 233,431.37**	**0.3915**
5100624100	**GENERAL INSPECTIONS**	5100011000	SALARIES AND WAGES--REGULAR	$ 712,237.00	$ 303,026.04	0.4255
		5100012300	SALARIES AND WAGES--OVERTIME	$ -	$ 546.27	X
		5100020100	PAY PLAN ADJUSTMENT	$ 7,299.00	$ -	-
		5100020500	PHONE ALLOWANCE	$ 2,100.00	$ 775.00	0.3690
		5100061000	FICA EXPENSE	$ 56,453.00	$ 22,432.41	0.3974
		5100061300	RETIREMENT	$ 52,131.00	$ 21,462.59	0.4117
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 36,882.00	$ 15,178.74	0.4115
		PERSONNEL		**$ 867,102.00**	**$ 363,421.05**	0.4191
		5200110200	TELEPHONE	$ 3,420.00	$ 1,096.39	0.3206
		5200110400	PRINTING SUPPLIES	$ 350.00	$ -	-
		5200114300	OFFICE SUPPLIES AND MATERIALS	$ 1,650.00	$ 1,530.64	0.9277
		5200130100	TRAINING RELATED TRAVEL	$ 5,790.00	$ 1,955.02	0.3377
		5200130300	DUES AND SUBSCRIPTIONS	$ 750.00	$ 618.50	0.8247
		5200140300	M & R EQUIPMENT	$ 1,500.00	$ -	-
		5200150100	OPERATIONAL TRAVEL	$ 8,200.00	$ 256.17	0.0312
		5200151000	SOFTWARE-NONCAPITAL	$ 3,720.00	$ 1,770.00	0.4758
		5200159500	MISCELLANEOUS SUPPLIES	$ 11,200.00	$ 324.71	0.0290
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$ 27,000.00	$ -	-
		5200180300	UNIFORMS	$ 825.00	$ 55.00	0.0667
		5200200000	NON-CAPITAL COMPUTER EQUIP	$ 7,893.00	$ -	-
		OPERATING		**$ 72,298.00**	**$ 7,606.43**	**0.1052**
		TOTAL		**$ 939,400.00**	**$ 371,027.48**	**0.3950**
5100624200	**PARENTING PROGRAMS**	5100011000	SALARIES AND WAGES--REGULAR	$ 49,500.00	$ -	-
		5100020500	PHONE ALLOWANCE	$ 540.00	$ -	-

		5100061000	FICA EXPENSE	$	3,787.00	$ -	-
		5100061300	RETIREMENT	$	3,500.00	$ -	-
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	2,475.00	$ -	-
		PERSONNEL		**$**	**59,802.00**	**$ -**	-
		5200130100	TRAINING RELATED TRAVEL	$	200.00	$ 70.82	0.3541
		5200150100	OPERATIONAL TRAVEL	$	1,400.00	$ 24.58	0.0176
		5200150400	FOOD AND PROVISIONS	$	1,960.00	$ -	-
		5200153500	CLIENT INCENTIVES	$	3,000.00	$ -	-
		5200159500	MISCELLANEOUS SUPPLIES	$	4,972.00	$ -	-
		5200160100	MISCELLANEOUS CONTRACTED SERVI	$	154,281.00	$ -	-
		OPERATING		**$**	**165,813.00**	**$ 95.40**	**0.0006**
		TOTAL		**$**	**225,615.00**	**$ 95.40**	**0.0004**
5100624400	**WATER & WASTE INSPECTION**	5100011000	SALARIES AND WAGES--REGULAR	$	376,073.00	$ 137,530.97	0.3657
		5100020100	PAY PLAN ADJUSTMENT	$	4,748.00	$ -	-
		5100061000	FICA EXPENSE	$	29,145.00	$ 10,282.50	0.3528
		5100061300	RETIREMENT	$	26,911.00	$ 9,704.19	0.3606
		5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$	19,042.00	$ 6,862.84	0.3604
		PERSONNEL		**$**	**455,919.00**	**$ 164,380.50**	0.3605
		5200110200	TELEPHONE	$	3,000.00	$ 1,045.90	0.3486
		5200110400	PRINTING SUPPLIES	$	1,150.00	$ -	-
		5200114300	OFFICE SUPPLIES AND MATERIALS	$	1,650.00	$ 677.28	0.4105
		5200130100	TRAINING RELATED TRAVEL	$	2,702.00	$ 246.82	0.0913
		5200130300	DUES AND SUBSCRIPTIONS	$	350.00	$ 350.00	1.0000
		5200150100	OPERATIONAL TRAVEL	$	500.00	$ 28.25	0.0565
		5200152200	LABORATORY SUPPLIES	$	9,450.00	$ 2,001.50	0.2118
		5200159500	MISCELLANEOUS SUPPLIES	$	5,400.00	$ 1,503.76	0.2785
		5200180300	UNIFORMS	$	385.00	$ -	-
		OPERATING		**$**	**24,587.00**	**$ 5,853.51**	**0.2381**
		TOTAL		**$**	**480,506.00**	**$ 170,234.01**	**0.3543**
5100624500	**LOCAL PUBLIC HEALTH GRANT**	5100011000	SALARIES AND WAGES--REGULAR	$	60,277.00	$ 29,807.73	0.4945
		5100020100	PAY PLAN ADJUSTMENT	$	923.00	$ -	-
		5100020500	PHONE ALLOWANCE	$	300.00	$ -	-

5100061000	FICA EXPENSE	$ 4,684.00	$ 2,282.46	0.4873
5100061300	RETIREMENT	$ 4,325.00	$ 2,107.37	0.4873
5100063300	SUPPLMNTL RETREMNT INCOME PLAN	$ 3,060.00	$ 1,490.37	0.4870
PERSONNEL		**$ 73,569.00**	**$ 35,687.93**	0.4851
5200110200	TELEPHONE	$ 267.00	$ 38.01	0.1424
5200110400	PRINTING SUPPLIES	$ 1,388.00	$ -	-
5200114300	OFFICE SUPPLIES AND MATERIALS	$ 2,504.00	$ -	-
5200130100	TRAINING RELATED TRAVEL	$ 500.00	$ 50.00	0.1000
5200150100	OPERATIONAL TRAVEL	$ 300.00	$ (1.90)	(0.0063)
5200154200	OTHER MEDICAL SUPPLIES	$ 2,500.00	$ 859.14	0.3437
5200159500	MISCELLANEOUS SUPPLIES	$ 16,301.82	$ -	-
OPERATING		**$ 23,760.82**	**$ 945.25**	**0.0398**
TOTAL		**$ 97,329.82**	**$ 36,633.18**	**0.3764**
GRAND TOTAL FOR ALL FUND CENTERS		**$ 22,115,101.77**	**$ 9,658,195.01**	**0.4367**

PUBLIC HEALTH REVENUES AS OF 12/31/2013 10:07 AM

Commitment item	Name		Current Budget		Actuals	% Spent
4300311100	SYPHILIS ELIMINATION	$	(71,636.00)	$	(24,213.99)	0.3380
4300317500	STATE AID TO COUNTIES	$	(168,220.00)	$	(69,384.18)	0.4125
4300323500	FOOD AND NUTRITION SERVICE GRANT	$	(592,965.00)	$	(81,301.57)	0.1371
4300324100	MEDICAID	$	(1,772,849.00)	$	(481,225.37)	0.2714
4300324400	MEDICAID-OTHER	$	(259,114.00)	$	-	0.0000
4300325300	HEALTH EDUCATION GRANTS	$	(294,164.00)	$	(106,627.93)	0.3625
4300326500	FAMILY PLANNING: NEEDY FAMILY	$	(10,279.00)	$	(524.49)	0.0510
4300326600	WOMENS HEALTH FUND	$	(21,984.00)	$	(16,324.00)	0.7425
4300327000	CHILD FATALITY PREVENTION	$	(2,487.00)	$	(1,854.84)	0.7458
4300327200	COMMUNICABLE DISEASE GRANT	$	(189,998.00)	$	(119,527.67)	0.6291
4300327300	IMMUNIZATION SERVICES	$	(57,158.00)	$	(17,988.00)	0.3147
4300327700	LINCOLN AIDS CONTRACT	$	(28,000.00)	$	(16,333.00)	0.5833
4300327900	TUBERCULOSIS SCREENING	$	(4,767.00)	$	(1,589.00)	0.3333
4300328000	CANCER SCREENING	$	(29,121.00)	$	(18,105.00)	0.6217
4300328100	FAMILY PLANNING	$	(45,987.00)	$	(38,614.38)	0.8397
4300328200	MATERNAL HEALTH GRANT	$	(304,196.00)	$	(93,658.40)	0.3079
4300328400	ENVIRONMENTAL HEALTH	$	(4,000.00)	$	-	0.0000
4300328700	CHILD HEALTH COORDINATION	$	(76,131.00)	$	(31,024.78)	0.4075
4300328800	NUTRITION GRANT	$	(20,000.00)	$	(6,661.92)	0.3331
4300329100	FOOD AND LODGING	$	(27,893.00)	$	(6,893.00)	0.2471
4300329400	CDC TB GRANT	$	(39,133.00)	$	(22,828.00)	0.5833
4300329600	PUBLIC SCHOOLS GRANT	$	(100,000.00)	$	(42,845.92)	0.4285
4300330100	MCC GRANT	$	(35,160.00)	$	(13,918.93)	0.3959
4300338500	PH GRANT	$	(80,000.00)	$	(18,877.02)	0.2360
4300357700	GRANT REVENUES	$	(1,687,190.00)	$	(223,231.97)	0.1323
INTERGOVERNMENTAL REVENUES		**$**	**(5,922,432.00)**	**$**	**(1,453,553.36)**	**0.2454**
4510511000	USER FEES	$	(124,750.00)	$	(53,435.00)	0.4283
4510560300	GENERAL HEALTH FEES	$	(6,500.00)	$	(3,971.27)	0.6110
4510560400	IMMUNIZATIONS	$	(38,000.00)	$	(7,468.80)	0.1965
4510560500	DENTAL FEES	$	(42,000.00)	$	(21,770.73)	0.5184
4510560700	INMATE FEES	$	(4,000.00)	$	(1,400.32)	0.3501
4510561000	FAMILY PLANNING FEE SCALE	$	(20,000.00)	$	(7,072.44)	0.3536
4510561300	HOME HEALTH POSTPARDOM VISITS	$	(62,522.00)	$	(22,914.42)	0.3665

4510561500	NUTRITION FEES	$	(2,880.00)	$	(2,013.78)	0.6992
4510562800	PHARMACY FEES	$	-	$	(13,646.65)	X
4510563200	SCHOOL HEALTH CONTRACTS	$	-	$	(4,744.68)	X
4510565200	MEDICAID MAXIMIZATION	$	(50,910.00)	$	-	0.0000
SERVICE CHARGES		**$**	**(351,562.00)**	**$**	**(138,438.09)**	**0.3938**
4700730300	MISCELLANEOUS RECEIPTS	$	(1,350.00)	$	(192.01)	0.1422
OTHER REVENUES		**$**	**(1,350.00)**	**$**	**(192.01)**	**0.1422**
TOTAL REVENUES		**$**	**(6,275,344.00)**	**$**	**(1,592,183.46)**	**0.2537**

PUBLIC HEALTH REVENUES BY FUND CENTER AS OF 12/31/2013 10:07 AM

Fund Center	Fund Center Name	Commitment item	CI Name	Current Budget	Actuals	% Spent
5100621100	**PUBLIC HEALTH ADMINISTRATION**	4300317500	STATE AID TO COUNTIES	$ (26,132.00)	$ (41,878.53)	1.6026
		4300324400	MEDICAID-OTHER	$ (44,808.00)	$ -	0.0000
		4300327200	COMMUNICABLE DISEASE GRANT	$ (21,517.00)	$ (19,605.37)	0.9112
		4300327300	IMMUNIZATION SERVICES	$ (26,320.00)	$ (6,875.38)	0.2612
		INTERGOVERNMENTAL		**$ (118,777.00)**	**$ (68,359.28)**	**0.5755**
		4700730300	MISCELLANEOUS RECEIPTS	$ (1,350.00)	$ (192.01)	0.1422
		OTHER REVENUES		**$ (1,350.00)**	**$ (192.01)**	0.1422
		TOTAL		**$ (120,127.00)**	**$ (68,551.29)**	**0.5707**
5100621200	**DEPARTMENTAL**	4300317500	STATE AID TO COUNTIES	$ (120,499.00)	$ (24,007.68)	0.1992
		INTERGOVERNMENTAL		**$ (120,499.00)**	**$ (24,007.68)**	**0.1992**
		TOTAL		**$ (120,499.00)**	**$ (24,007.68)**	**0.1992**
5100621500	**NUTRITION**	4300323500	FOOD AND NUTRITION SERVICE GRANT	$ (592,965.00)	$ (81,301.57)	0.1371
		4300324100	MEDICAID	$ (16,964.00)	$ (2,535.12)	0.1494
		4300324400	MEDICAID-OTHER	$ (83,247.00)	$ -	0.0000
		4300328800	NUTRITION GRANT	$ (20,000.00)	$ (6,661.92)	0.3331
		INTERGOVERNMENTAL		**$ (713,176.00)**	**$ (90,498.61)**	**0.1269**
		4510561500	NUTRITION FEES	$ (2,880.00)	$ (2,013.78)	0.6992
		SERVICE CHARGES		**$ (2,880.00)**	**$ (2,013.78)**	**0.6992**
		TOTAL		**$ (716,056.00)**	**$ (92,512.39)**	**0.1292**
5100621600	**HEALTH EDUCATION**	4300311100	SYPHILIS ELIMINATION	$ (71,636.00)	$ (24,213.99)	0.3380
		4300317500	STATE AID TO COUNTIES	$ (21,589.00)	$ (3,497.97)	0.1620
		4300325300	HEALTH EDUCATION GRANTS	$ (294,164.00)	$ (106,627.93)	0.3625
		4300326500	FAMILY PLANNING: NEEDY FAMILY	$ (10,279.00)	$ (524.49)	0.0510
		4300327200	COMMUNICABLE DISEASE GRANT	$ (25,000.00)	$ (10,214.86)	0.4086
		4300357700	GRANT REVENUES	$ (11,000.00)	$ (14,817.36)	1.3470
		INTERGOVERNMENTAL		**$ (433,668.00)**	**$ (159,896.60)**	**0.3687**
		TOTAL		**$ (433,668.00)**	**$ (159,896.60)**	**0.3687**

5100621700	**LABORATORY**	4300324100	MEDICAID	$ (40,000.00)	$ -	0.0000
		INTERGOVERNMENTAL		**$ (40,000.00)**	**$ -**	**0.0000**
		TOTAL		**$ (40,000.00)**	**$ -**	**0.0000**
5100621800	**DENTAL**	4300324100	MEDICAID	$ (146,000.00)	$ -	0.0000
		4300324400	MEDICAID-OTHER	$ (25,000.00)	$ -	0.0000
		INTERGOVERNMENTAL		**$ (171,000.00)**	**$ -**	**0.0000**
		4510560500	DENTAL FEES	$ (42,000.00)	$ (21,770.73)	0.5184
		SERVICE CHARGES		**$ (42,000.00)**	**$ (21,770.73)**	**0.5184**
		TOTAL		**$ (213,000.00)**	**$ (21,770.73)**	**0.1022**
5100622100	**GENERAL HEALTH**	4300324100	MEDICAID	$ (60,097.00)	$ (23,996.83)	0.3993
		4300327200	COMMUNICABLE DISEASE GRANT	$ (63,200.00)	$ (45,572.57)	0.7211
		4300357700	GRANT REVENUES	$ (10,244.00)	$ (6,208.00)	0.6060
		INTERGOVERNMENTAL		**$ (133,541.00)**	**$ (75,777.40)**	**0.5674**
		4510560300	GENERAL HEALTH FEES	$ (1,500.00)	$ (109.27)	0.0728
		SERVICE CHARGES		**$ (1,500.00)**	**$ (109.27)**	**0.0728**
		TOTAL		**$ (135,041.00)**	**$ (75,886.67)**	**0.5620**
5100622200	**IMMUNIZATION**	4300324100	MEDICAID	$ (16,000.00)	$ (8,046.52)	0.5029
		4300327300	IMMUNIZATION SERVICES	$ (30,838.00)	$ (11,112.62)	0.3604
		INTERGOVERNMENTAL		**$ (46,838.00)**	**$ (19,159.14)**	**0.4091**
		4510560400	IMMUNIZATIONS	$ (38,000.00)	$ (7,468.80)	0.1965
		SERVICE CHARGES		**$ (38,000.00)**	**$ (7,468.80)**	**0.1965**
		TOTAL		**$ (84,838.00)**	**$ (26,627.94)**	**0.3139**
5100622300	**TUBERCULOSIS SCREENING**	4300327200	COMMUNICABLE DISEASE GRANT	$ (80,281.00)	$ (44,134.87)	0.5498
		4300327900	TUBERCULOSIS SCREENING	$ (4,767.00)	$ (1,589.00)	0.3333
		4300329400	CDC TB GRANT	$ (39,133.00)	$ (22,828.00)	0.5833
		INTERGOVERNMENTAL		**$ (124,181.00)**	**$ (68,551.87)**	**0.5520**

		TOTAL		**$ (124,181.00)**	**$ (68,551.87)**	**0.5520**
5100622400	**PHARMACY**	4300324100	MEDICAID	$ -	$ (191.58)	X
		INTERGOVERNMENTAL		**$ -**	**$ (191.58)**	**X**
		4510562800	PHARMACY FEES	$ -	$ (13,646.65)	X
		SERVICE CHARGES		**$ -**	**$ (13,646.65)**	**X**
		TOTAL		**$ -**	**$ (13,838.23)**	**X**
5100622500	**FAMILY PLANNING**	4300324100	MEDICAID	$ (100,000.00)	$ (174.08)	0.0017
		4300326600	WOMENS HEALTH FUND	$ (21,984.00)	$ (16,324.00)	0.7425
		4300328100	FAMILY PLANNING	$ (45,987.00)	$ (38,614.38)	0.8397
		4300328200	MATERNAL HEALTH GRANT	$ (102,154.00)	$ (26,706.00)	0.2614
		INTERGOVERNMENTAL		**$ (270,125.00)**	**$ (81,818.46)**	**0.3029**
		4510561000	FAMILY PLANNING FEE SCALE	$ (20,000.00)	$ (7,072.44)	0.3536
		4510565200	MEDICAID MAXIMIZATION	$ (50,910.00)	$ -	0.0000
		SERVICE CHARGES		**$ (70,910.00)**	**$ (7,072.44)**	**0.0997**
		TOTAL		**$ (341,035.00)**	**$ (88,890.90)**	**0.2607**
5100622600	**ADULT HEALTH**	4300328000	CANCER SCREENING	$ (29,121.00)	$ (18,105.00)	0.6217
		INTERGOVERNMENTAL		**$ (29,121.00)**	**$ (18,105.00)**	**0.6217**
		TOTAL		**$ (29,121.00)**	**$ (18,105.00)**	**0.6217**
5100622700	**AIDS CONTROL**	4300327700	LINCOLN AIDS CONTRACT	$ (28,000.00)	$ (16,333.00)	0.5833
		4300357700	GRANT REVENUES	$ (161,926.00)	$ -	0.0000
		INTERGOVERNMENTAL		**$ (189,926.00)**	**$ (16,333.00)**	**0.0860**
		TOTAL		**$ (189,926.00)**	**$ (16,333.00)**	**0.0860**
5100622900	**DIABETES COALITION PROJECT**	4300357700	GRANT REVENUES	$ (1,210,523.00)	$ (142,135.79)	0.1174
		INTERGOVERNMENTAL		**$ (1,210,523.00)**	**$ (142,135.79)**	**0.1174**

		TOTAL		**$ (1,210,523.00)**	**$ (142,135.79)**	**0.1174**
5100623100	**GENERAL NURSING**	4300327000	CHILD FATALITY PREVENTION	$ (2,487.00)	$ (1,854.84)	0.7458
		INTERGOVERNMENTAL		**$ (2,487.00)**	**$ (1,854.84)**	**0.7458**
		TOTAL		**$ (2,487.00)**	**$ (1,854.84)**	**0.7458**
5100623200	**MATERNAL HEALTH**	4300324100	MEDICAID	$ (300,000.00)	$ (81,664.12)	0.2722
		4300324400	MEDICAID-OTHER	$ (106,059.00)	$ -	0.0000
		4300328200	MATERNAL HEALTH GRANT	$ (184,627.00)	$ (59,267.94)	0.3210
		INTERGOVERNMENTAL		**$ (590,686.00)**	**$ (140,932.06)**	**0.2386**
		4510560300	GENERAL HEALTH FEES	$ (5,000.00)	$ (3,862.00)	0.7724
		SERVICE CHARGES		**$ (5,000.00)**	**$ (3,862.00)**	**0.7724**
		TOTAL		**$ (595,686.00)**	**$ (144,794.06)**	**0.2431**
5100623300	**CHILD HEALTH**	4300324100	MEDICAID	$ (620,292.00)	$ (207,724.80)	0.3349
		4300328700	CHILD HEALTH COORDINATION	$ (76,131.00)	$ (31,024.78)	0.4075
		INTERGOVERNMENTAL		**$ (696,423.00)**	**$ (238,749.58)**	**0.3428**
		TOTAL		**$ (696,423.00)**	**$ (238,749.58)**	**0.3428**
5100623500	**JAIL**	4510560700	INMATE FEES	$ (4,000.00)	$ (1,400.32)	0.3501
		SERVICE CHARGES		**$ (4,000.00)**	**$ (1,400.32)**	**0.3501**
		TOTAL		**$ (4,000.00)**	**$ (1,400.32)**	**0.3501**
5100623600	**SCHOOL HEALTH**	4300328200	MATERNAL HEALTH GRANT	$ (17,415.00)	$ (7,684.46)	0.4413
		4300329600	PUBLIC SCHOOLS GRANT	$ (100,000.00)	$ (42,845.92)	0.4285
		4300357700	GRANT REVENUES	$ (60,000.00)	$ (60,000.00)	1.0000
		INTERGOVERNMENTAL		**$ (177,415.00)**	**$ (110,530.38)**	**0.6230**
		4510563200	SCHOOL HEALTH CONTRACTS	$ -	$ (4,744.68)	
		SERVICE CHARGES		**$ -**	**$ (4,744.68)**	**X**
		TOTAL		**$ (177,415.00)**	**$ (115,275.06)**	**0.6497**

Org	Name	Account	Description	Budget	Actual	Percent
5100623800	**DURHAM CONNECTS**	4510561300	HOME HEALTH POSTPARDOM VISITS	$ (62,522.00)	$ (22,914.42)	0.3665
		SERVICE CHARGES		**$ (62,522.00)**	**$ (22,914.42)**	**0.3665**
		TOTAL		**$ (62,522.00)**	**$ (22,914.42)**	**0.3665**
5100623900	**BABY LOVE PROGRAM**	4300324100	MEDICAID	$ (473,496.00)	$ (156,892.32)	0.3313
		4300330100	MCC GRANT	$ (35,160.00)	$ (13,918.93)	0.3959
		INTERGOVERNMENTAL		**$ (508,656.00)**	**$ (170,811.25)**	**0.3358**
		TOTAL		**$ (508,656.00)**	**$ (170,811.25)**	**0.3358**
5100624100	**GENERAL INSPECTIONS**	4300328400	ENVIRONMENTAL HEALTH	$ (4,000.00)	$ -	0.0000
		4300329100	FOOD AND LODGING	$ (27,893.00)	$ (6,893.00)	0.2471
		INTERGOVERNMENTAL		**$ (31,893.00)**	**$ (6,893.00)**	**0.2161**
		4510511000	USER FEES	$ (24,000.00)	$ (15,375.00)	0.6406
		SERVICE CHARGES		**$ (24,000.00)**	**$ (15,375.00)**	**0.6406**
		TOTAL		**$ (55,893.00)**	**$ (22,268.00)**	**0.3984**
5100624200	**PARENTING PROGRAMS**	4300357700	GRANT REVENUES	$ (233,497.00)	$ (70.82)	0.0003
		INTERGOVERNMENTAL		**$ (233,497.00)**	**$ (70.82)**	**0.0003**
		TOTAL		**$ (233,497.00)**	**$ (70.82)**	**0.0003**
5100624400	**WATER & WASTE INSPECTION**	4510511000	USER FEES	$ (100,750.00)	$ (38,060.00)	0.3778
		SERVICE CHARGES		**$ (100,750.00)**	**$ (38,060.00)**	**0.3778**
		TOTAL		**$ (100,750.00)**	**$ (38,060.00)**	**0.3778**
5100624500	**LOCAL PUBLIC HEALTH GRANT**	4300338500	PH GRANT	$ (80,000.00)	$ (18,877.02)	0.2360
		INTERGOVERNMENTAL		**$ (80,000.00)**	**$ (18,877.02)**	**0.2360**
		TOTAL		**$ (80,000.00)**	**$ (18,877.02)**	**0.2360**

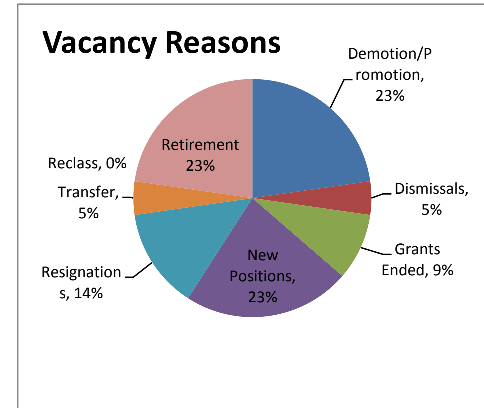
GRAND TOTAL FOR ALL FUND CENTERS	**$ (6,275,344.00)**	**$ (1,592,183.46)**	**0.2537**

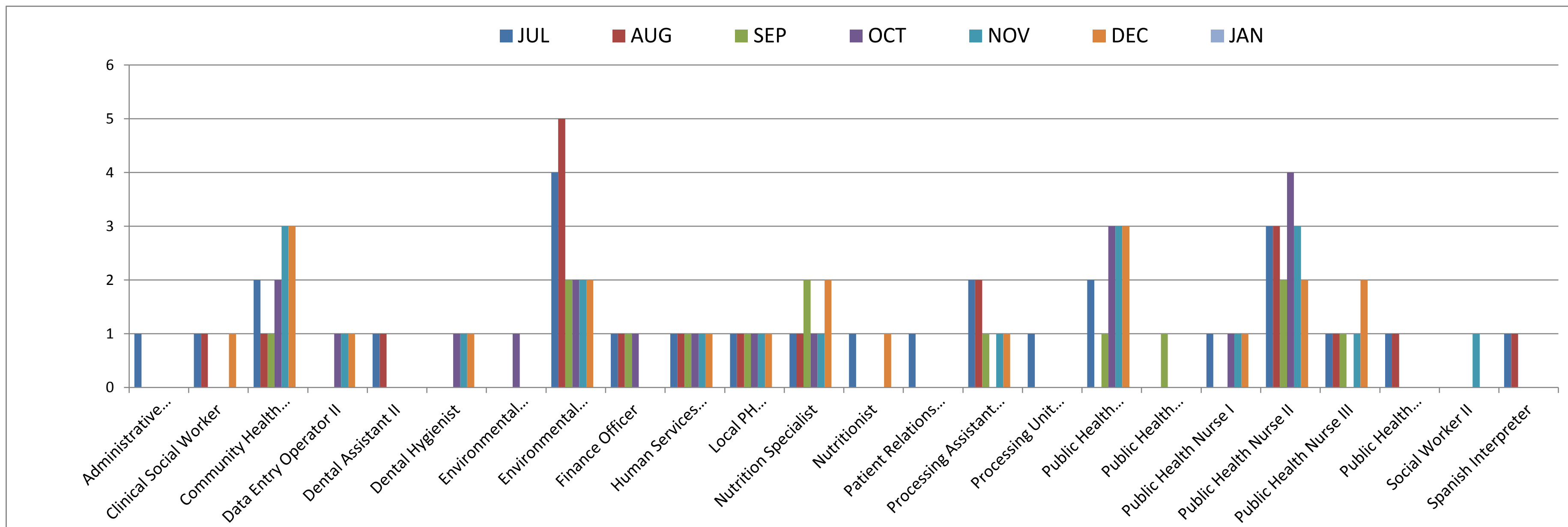
PUBLIC HEALTH VACANCY REPORT
FY 2013/2014

Vacancy Report FY 2013/2014

	JUL	AUG	SEP	OCT	NOV	DEC	JAN
Administrative Assistant I	1						
Clinical Social Worker	1	1				1	
Community Health Assistant	2	1	1	2	3	3	
Data Entry Operator II				1	1	1	
Dental Assistant II	1	1					
Dental Hygienist				1	1	1	
Environmental Health Director				1			
Environmental Health Specialist	4	5	2	2	2	2	
Finance Officer	1	1	1	1			
Human Services Coordinator III	1	1	1	1	1	1	
Local PH Administrator	1	1	1	1	1	1	
Nutrition Specialist	1	1	2	1	1	2	
Nutritionist	1					1	
Patient Relations Rep IV	1						
Processing Assistant III	2	2	1		1	1	
Processing Unit Supervisor	1						
Public Health Education Specialist	2		1	3	3	3	
Public Health Educator I			1				
Public Health Nurse I	1			1	1	1	
Public Health Nurse II	3	3	2	4	3	2	
Public Health Nurse III	1	1	1		1	2	
Public Health Nursing Supervisor I	1	1					
Social Worker II					1		
Spanish Interpreter	1	1					
Total Vacancies	**27**	**20**	**14**	**19**	**20**	**22**	**0**

Vacancy Reasons (Dec)	#	%
Demotion/Promotion	5	23%
Dismissals	1	5%
Grants Ended	2	9%
New Positions	5	23%
Resignations	3	14%
Transfer	1	5%
Reclass	0	0%
Retirement	5	23%
	22	





Durham County Department of Public Health

Environmental Health Division

Notice of Violation Report (NOV) Report

January 9, 2014 BOH Meeting

NOV DATE	SUBJECT PROPERTY ADDRESS	TYPE OF VIOLATION	NOV EXPIRATION DATE	FORWARDED TO CO. ATTY?	COMPLIANCE STATUS (YES/NO)	COMPLIANCE DATE	NOTES
10/1/2012	3903 Hanford Dr	Surfacing effluent and unpermitted modification of the existing system.	10/31/2012	Y	N		Turned down for a repair on 9/24/2012. Recommended for legal action 11/02/2012 Case has been adjudicated in court. No change regarding site conditions. 10/7/2013.Not failing at this time trailer removed from site, not occupied. Scattered Site grant. Drew Cummings. Reduced water usage is likely the reason there is not an active failure at this time 11/26/2013.
10/1/2012	3823 Hanford Dr	Surfacing effluent and unpermitted modification of the existing system.	10/31/2012	Y	N		Turned down for a repair on 9/24/2012. House is not occupied, but system has been modified to discharge. Recommended for legal action 11/02/2012. Case has been adjudicated in court. No change regarding site conditions. NOV issued this is a straight pipe situation. House previously unoccupied. Mr. Durham has moved back in. He has been made aware of the straight pipe, informed to keep the tanks pumped until the issue is resolved and

							instructed to pursue discharging permit with DWR. 12/6/2013.
1/7/2013	4919 FARRINGTON RD	Surface discharge of effluent	2/15/2013	Y	N	Repair permit issued 12/4/13 Installation Pending.	Failing LPP System , NOV issued to have owner to complete repair application so site can be evaluated for repair options. No application has been received from property owners, file forwarded to County Attorney's office 5/2/2013. 9/27/2013 Received report from Brantley, still failing, forwarded report to attorney. 10/30/2013, Verified via site visit that the system is still failing, new NOV issued. Repair permit issued 12/4/2013.

3/14/2013	2707 Little River Dr	Surface discharge of effluent	4/14/2013	N	N		Application for repair permit has been received, Met septic contractor onsite 3/12/13. System determined to be non-repairable. New NOV issued directing property owner to pursue 10/31/2013, permit for discharging system through NC DWQ. 9/30/13 - No application has been received by NC DWR. Site visit scheduled for 10/8/2013 to verify failure prior to forwarding to County Attorney. 10/31/2013 Verified via site visit that the system is still failing. Issued new NOV on 10/31/2013, which expired 12/2/2013. There has been no response, legal action is recommended. 12/6/2013.
6/17/2013	3500 Donnigale	Effluent surfacing over septic tank	7/19/2013	Y	N	Mr. Wardell to send letter to owner if no response in 10 days county will file suit.	Failing, sewer is available. 7/29/2013 Have received no response from homeowner, nor has application for sewer been made NOV Forwarded to County Attorney. 10/23/2013 - Property remains unconnected to sewer.

7/17/2013	3038 Tavistock Dr	Surfacing sewage and accessory dwelling build without permit.	8/17/2013	N	N	Forwarded to County Attorney's office for legal action 12/27/2013.	Discovered during monitoring visit 9/23/2013. 10/7/2013 No attempt has been made to correct the situation. Recommend for County Attorney's Office.
8/19/2013	2121 Fletchers Chapel	Damaged septic tank	9/18/2013	N	N	Property vacated. Left notice for owner to remove damaged tank.	9/4/2013 clarified repair question via email. Still need a repair application to replace the tank. 10/7/2013, application has been received and the repair permit has been issued, waiting for installation. Installation still pending, situation being monitored.
9/26/2013	5901 Boylan	Failing Mound LPP	10/28/2013	N	N	Repair permit issued 12/11/2013. Installation pending.	Failing LPP (Repair Application has been received- 10/7/2013) Meeting with NCDHHS Regional Soil Scientist set for week of 11/18/2013 for evaluation. Meeting with Kevin Neal on 11/20/2013. Repair permit issued 12/11/2013

9/5/2013	2804 Darrow Rd	Disconnected Municipal Sewer	10/5/2013	N	N		House was disconnected from municipal sewer by City of Durham Public Works Dept because of non-payment. Sewer clean out has been shattered causing wastewater/solids to discharge to ground surface. NOV issued citing NCGS 130A-335(a). NOV requires reconnection to sewer. 10/7/2013 - message left with City of Durham Public Works inquiring about the connection status prior to forwarding NOV to County Attorney. Sent to County Attorney to file suit on 11/4/2013. Complaint filed in superior court 11/21/2013.
5/31/2013	4009 Suitt	Surface discharge of effluent	2/15/2013	N	Y		Sewage is surfacing over drainfield of pump repair system. Sewage was diverted to an old existing gravity system. This is a short term patch, failure is imminent. The homeowner will need to pursue a long term solution with DWQ. System is being monitored by Env Health. Alternating between drainfields, no malfunction at this time. Being monitored by Environmental Health.

	5100 Glenn Rd	Effluent surfacing	7/1/2013	N	Y		Complaint driven, verified from the road. The house is currently unoccupied 7/29/2013 Up for sale, being monitored. No change in status.

Creating a Community Resource Connection (CRC) in Durham County for Older Adults and People with Disabilities
DRAFT 2/11/2013

The Request: *To support the creation of a new position to work with Durham Partnership for Seniors and partners in the disability services community to: 1) build upon the work of these groups; and 2) to create a Durham-based CRC (Community Resource Connection) for seniors and adults with disabilities.*

Background:

- According to census data, the population of Durham County residents who were 60 and older in 2010 was 38,779 or 14.5% of the total population. This age cohort is projected to grow to 71,471 or 18.8% of the County's population by 2030 (NC Division of Aging and Adult Services County Profile posted 2/2012). This projected growth is 2.5 faster than other age groups in Durham. The agencies that work with older adults need to collectively "gear up" for this massive growth, ensuring that we have a variety of services to meet the disparate needs of the "new" seniors and their aging neighbors.
- Even now – there are many seniors on waiting lists for services that could greatly enhance their lives. While we must plan for the future, we also have to take stock in how to best use our resources now. If we continue to operate in silos and think only "inside our boxes," we will continue to have many older adults who fall through the cracks of our senior safety net.
- In addition, there are thousands of adults with physical and/or developmental disabilities who also struggle to find the supports they need to remain as healthy and independent as possible in Durham. A CRC is mandated to provide resources and referral to adults with disabilities. While there is a commonality of needs between both the aging and disability populations, people with disabilities have specific and unique assets to bring to our work. The US Department of Health and Human Services estimates that at least 18% of the adult population has a disability.
- Many communities in North Carolina and indeed across the nation have responded to the growing aging population and the challenges faced by younger people with disabilities – in a collaborative community-based response by creating what is nationally called ADRCs (Aging and Disability Resource Centers). The effort in NC is dubbed CRC or Community Resource Connections highlighting the fact that a web of connected providers and services are needed to meet our challenges. Both Wake and Orange/Chatham have CRCs in place and we understand that $15,000 in state funding is available now to help create a CRC in Durham; however, this opportunity may be fleeting. The hope is that the State will continue to fund these collaborative networks moving forward.
- Durham's Commissioners have individually endorsed Durham developing a CRC (Durham CAN assembly - Fall 2012). And fortunately, Durham does not have to start from scratch as the Durham Partnership for Seniors and partners in the disability services community have been doing similar work for years.

What is a Community Resource Connection (CRC)?

A partnership/coalition/collaborative that:

- joins the aging and disability communities to coordinate commonalities and system overlap, while also acknowledging differences and system gaps
- enhances the availability of and outreach about resources to underserved populations.
- honors memorandums of understanding that create a user-friendly and practical "no wrong door" system of care where seniors and people with disabilities (and the family members and people in agencies who work with them) can access information about the services they need.
- Uses technology effectively to both streamline access (i.e. Web-based resource databases, online applications & decision support tools) and creates administrative efficiencies (i.e. exchanging eligibility as appropriate across partner agencies)
- focuses on consumer needs and satisfaction such that seniors and persons with disabilities understand their options and have access to the information they need to make good choices

- creates shared accountability when appropriate and shares in the decision-making and credit when applicable but also confronts challenges together; agencies and programs retain their sovereignty while also operating together within the CRC

Why is a Coordinator needed:
Like the Partnership for Healthy Durham, which has a coordinator housed in the Durham County Department of Health, the Durham Partnership for Seniors (DPfS) and the disability services community believe that a coordinator focused on developing, implementing and sustaining a CRC in Durham will move our collective efforts forward at a critical time. We are challenged to better understand and then address the growing needs of seniors and adults with disabilities in our community.

The DPfS is a well-established group, comprised of agency leaders and interested community members, that has historically focused on senior issues. Recently, the group has expanded to include agencies and individuals who also serve younger people with disabilities. For years, DPfS has been the coalition responsible for making funding recommendations about state block grants for aging services to the Durham County Commissioners. This coalition also served as the United Way's senior issue team for several years and more recently, as the City-County "results-based accountability" team for seniors issues and Durham Health Innovation's senior planning team. The momentum of this group is growing with new partners joining in our efforts: including Durham CAN, Durham Cares, First in Families; Long Term Care Ombudsman program; CAARE clinic; Senior Health Support of the Triangle, and others. Long-standing members include Triangle J Area Agency on Aging, Durham County Department of Health, Durham County DSS Adult Services; Durham Center for Senior Life, Senior PharmAssist, Meals on Wheels, RSVP, A Helping Hand, Project Compassion, members of various faith communities, long-term care providers, Durham Community Health Network with the Duke Division of Community and Family Medicine, and others. We realize that meaningful change will be necessary if we are to rise to the challenges of a booming aging population, shrinking resources for people with disabilities, and a trend towards limited governmental funding. We have to "do more – with less." Collaborative planning and shared knowledge and resources are some of the methods for combatting these negative trends. We understand that together we can accomplish much more than if we each work in isolation. **We request that Durham County join the state CRC movement by providing $20,000 in support (that will be matched by CRC and private funds) for a new CRC coordinator position.**

We believe that the CRC Coordinator could physically be housed in the Durham County Department of Health – Division of Health Education – so s/he can work closely with the Partnership for a Healthy Durham Coordinator. They can both learn and share best practices for coalition-building, use of demographic statistics, shared accountability, and how to strategically move the Durham community forward in our efforts to make Durham a healthier place to live, work, and play for all ages and abilities. The fiscal oversight for the position would be identical to the CRCs in Wake and Orange/Chatham as it would be the responsibility of the Triangle J Area Agency on Aging. Their expertise and leadership will be invaluable. The CRC Coordinator will work with the DPfS and the disability services community to determine how to proceed with the CRC application and implementation.

CRC Coordinator Job Description:

Coordinates the planning, implementation and evaluation of the work of the Durham CRC working with both the Durham Partnership for Seniors (DPfS) and the partners in the disability services community. Required functions include awareness and information about long-term support options (in-home and institutional), assistance in identifying preferences and navigating options, and access to public and private pay support options.

Responsibilities:

- Work with the DPfS and the disability services community to create memorandums of agreement (MOAs) between lead agencies and other community partners as we jointly agree on how a CRC in Durham will function.
- Recruit volunteers and partnering agencies and coordinate training with collaborating programs.
- Work with the DPfS and the disability services community to develop a stream-lined system (or enhance an existing system) that provides information and referral, intake and screening, options and benefits counseling, access to public and private long-term care services and interventions to prevent inappropriate hospital readmissions.
- Facilitate linkages between community-based organizations and local hospitals to better coordinate transitions in care.
- Develop and implement an education and outreach campaign to inform consumers, the public and long-term care service professionals (including home care) about services available from the Durham CRC.
- Coordinate and make available informational materials used by partner agencies.
- Ensure ongoing evaluation to assess the collaboration's success in accomplishing intended goals.
- Work with DPfS and the disability services community to pursue funding for position and for other services needed in the community to enhance the life of older adults and people with disabilities.
- Work with the Partnership for a Healthy Durham Coordinator to ensure that useful information about seniors and adults with disabilities is included in the Durham County Community Health Assessment (CHA) and the State of the County Health (SOTCH) report.
- Plan for the sustainability of the CRC and the Coordinator Position.

Desired Educational Requirements:

- A master's degree in a field of study related to human services and/or public administration with at least two (2) years experience in the field; or
- A bachelor's degree in a field of study related to human services with at least four (4) years of experience providing services to persons with disabilities and/or those in the aging community.

Additional Requirements:

- Ability to work well with people of all backgrounds, incomes, ages, races and disabilities
- Ability to work collaboratively and build consensus among stakeholders
- Excellent organizational skills, including the ability to perform tasks at all levels
- Management/supervisory and customer service experience
- Knowledge of senior and disabled adults
- Knowledge of the long term care services continuum
- Excellent oral and written communication skill

Supervision:

- The CRC Coordinator is funded through and supervised by the Director of the Triangle J Area Agency on Aging (just like the Wake County and Orange/Chatham CRCs). However, the CRC coordinator's office will be in the Durham County Human Services building so s/he can work closely with her/his colleague who is the Coordinator for the Partnership for a Healthy Durham at the Durham County Department of Health. The CRC Coordinator also receives performance feedback from the members of Durham Partnership for Seniors and representatives from the disability services community.

American Association of Public Health Physicians
The voice of public health physicians, guardians of the public's health
Tobacco Control Task Force
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April 2, 2010

AAPHP Statement re State Regulation of E-cigarettes

The American Association of Public Health Physicians recommends the following State response to proposed legislation to ban or otherwise restrict the sale and use of nicotine vaporizers (commonly referred to as E-cigarettes or electronic cigarettes).

1. Sale to adults should be permitted.
2. Sale to minors should be banned.
3. AAPHP takes no stance on the question of whether E-cigarettes should be banned in no-smoking areas. (see explanation)

An E-cigarette is not a cigarette. It is a metal tube made to look like a cigarette, with a battery, heating element and cartridge containing the substance to be vaporized. The substance is usually a mixture of propylene glycol, glycerin, flavoring, and a specified quantity of nicotine. When the vaper (person using the E-cigarette) inhales, an LED lights up to make the device look more like a cigarette. When he or she exhales, there is a visible cloud of vapor that disappears within a few seconds.

Neither I (Dr. Joel Nitzkin) nor the organization I represent (the American Association of Public Health Physicians) have received or anticipate receipt of any financial support from any E-cigarette, tobacco-related or pharmaceutical enterprise.

AAPHP favors a permissive approach to E-cigarettes because the possibility exists to save the lives of four million of the eight million current adult American smokers who will otherwise die of a tobacco-related illness over the next twenty years.

The only feasible way to achieve this remarkable public health benefit will be to inform smokers of the differences in risk posed by different categories of nicotine-delivery products. Conventional cigarettes account for about 80% of nicotine consumption in the United States, but more than 98% of the illness and death. This harm is not caused by the nicotine, but by toxic products of combustion. A cigarette smoker can reduce his or her risk of future tobacco-related death by 98% or better by switching to a low risk smokeless tobacco product. He or she could cut that risk by 99.9% or better by switching to a nicotine-only delivery product like one of the pharmaceutical products or E-cigarettes.

Experience suggests that E-cigarettes may be more acceptable to smokers than the currently available pharmaceutical alternatives. A smoker can secure almost all the health benefits of quitting if he or she transitions to an E-cigarette.

Quitting, of course, is best. About 3% of smokers succeed in quitting each year. Pharmaceutical smoking cessation products, when used as directed, can increase that to about 7%. Thus, the current pharmaceutical products fail 93% of those who try them, even with the best of health education and counseling. Long term use of an alternative nicotine delivery product can achieve almost all of the benefits of quitting for those unable or unwilling to quit.

E-cigarettes can and should be marketed as a substitute for conventional cigarettes for smokers unable or unwilling to quit. State legislatures and, hopefully the FDA should see them in this light and regulate their marketing to reflect this purpose. Given the current lack of federal regulation, some, but not all, E-cigarette vendors adhere to this guideline.

Sales to minors should be prohibited. If someone does not become addicted to nicotine as a minor, it is unlikely that he or she will ever become addicted.

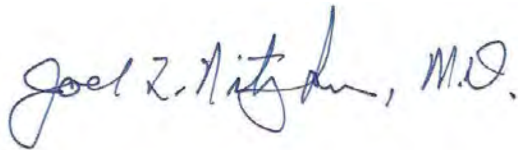
E-cigarettes deliver the same nicotine found in the pharmaceutical products, with no more contamination by toxic substances than the pharmaceutical products already approved by FDA. Propylene glycol and glycerin are used as

carriers of the nicotine. These cause the visible vapor. These substances are generally recognized as safe. They are commonly used in theatrical fog machines, asthma inhalers and air fresheners. There is no smoke, and no products of combustion. All this creates a situation in which we can confidently state that the risk to others sharing an indoor environment with one or more vapers (E-cigarette users actively using this product) is almost sure to be much less than 1% the risk posed by environmental tobacco smoke. Pharmaceutical nicotine vaporizers have been in use for years, with no visible vapor, and no apparent concern about use in non-smoking areas. This having been said, we cannot rule out the possibility that some individuals who may be extremely sensitive to indoor air irritants or to miniscule concentrations of nicotine in indoor air might be adversely affected by E-cigarette (or pharmaceutical nicotine vaporizer) vapor.

Another issue is that of modeling. Some worry that sight of E-cigarettes in non-smoking areas will make smoking restrictions harder to enforce, or encourage minors to see smoking as a "normal" and acceptable behavior. It is important to note that, on second glance, E-cigarettes are easy to distinguish from tobacco cigarettes. Those seeing this as a major issue are inclined to ban use of E-cigarettes in non-smoking areas.

We therefore recommend that research be done to address these two issues (possible hazard to a very small number of highly sensitive individuals and modeling). The problem here is that, with end points so difficult to document, such research could cost millions of dollars and take many years to complete. For the reasons noted above, we do not offer a stance in favor of or against banning E-cigarettes in non-smoking areas.

For the data and analyses behind these recommendations, please go to the Tobacco Issues page on our www.aaphp.org web site and download the two petitions to FDA (about 20 pages apiece). For yet additional information you can download other documents and the 303 pages of technical reference material relating to the petitions. I would also be happy to respond to any questions or concerns by E-mail.



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12-04

STATEMENT OF POLICY

Regulation of Electronic Cigarettes ("E-Cigarettes")

Policy

The National Association of County and City Health Officials (NACCHO) urges the FDA to enact strict regulations overseeing the sale and use of e-cigarettes and to conduct research on their health impact. Until then, NACCHO encourages local health departments (LHDs) to support local legislation that includes any or all of the following measures: [1,2]

- Use broadly-defined language to include e-cigarettes in new smoke-free legislation for indoor and outdoor environments
- Make clear that e-cigarettes are covered by existing smoke-free laws through clarifying opinion or regulation/rule (n.b.: opening up or amending the definitions of "smoke" and "smoking" to include e-cigarettes and e-cigarette vapor may jeopardize existing laws)
- Oppose legislation at the local or state level that exempts e-cigarettes from current smoking ban policies and regulations
- Require tobacco retailer licenses to sell e-cigarettes, or add an additional fee for existing tobacco retailers to sell e-cigarettes
- Establish an ordinance limiting the number of retailers or locations where e-cigarettes can be sold
- Prohibit sales of e-cigarettes to minors
- Ban sales of e-cigarette components that may appeal to minors, such as flavored cartridges
- Advocate for state or federal regulation prohibiting sales of e-cigarettes on the internet or through the mail, especially in the case of minors
- Raise excise tax on e-cigarettes as cigarettes and other tobacco products are taxed
- Work with businesses and public locations, such as malls, to voluntarily prohibit e-cigarette sales on premises

Justification

In April 2011, the Food and Drug Administration (FDA) announced that it intends to develop regulations for e-cigarettes.[3] E-cigarettes are battery-operated products designed to deliver nicotine, flavor, and other chemicals through a vapor inhaled by the user.[4] Most e-cigarettes are manufactured to resemble cigarettes, cigars, and pipes[5], often with an LED light at the tip that mimics the glow of a traditional cigarette.[6] According to a survey by the Centers for Disease Control and Prevention, the number of Americans who had ever used e-cigarettes quadrupled from 2009 to 2010, and 1.2 percent of adults, or nearly three million people, reported using e-cigarettes in the previous month.[7]

NACCHO recognizes the importance of finding new tools to help smokers quit. Currently, little scientific evidence exists to show that electronic cigarettes, or e-cigarettes, are effective cessation devices. Furthermore, in 2010, a federal court ruling blocked the FDA's attempts to regulate them as drugs or drug delivery devices, as nicotine gum and nicotine replacement therapy are regulated.[8]

Until further research shows that they are safe and effective, NACCHO suggests that e-cigarettes are regulated to the extent that the law allows. To that end, the FDA has the authority to regulate e-cigarettes as tobacco products under the Tobacco Control Act. According to the provisions of the act, state and local governments can take additional steps to regulate the sale and use of tobacco products and enact measures that are more restrictive than federal law.[9]

Further research is needed on the health risks of e-cigarettes, but available evidence suggests harmful effects. A recent study published in the European Respiratory Journal found that e-cigarette users get as much nicotine from e-cigarettes as smokers usually get from tobacco cigarettes.[10] The FDA warns users of the potential health risks posed by e-cigarettes.[11, 12] In addition to nicotine, an FDA laboratory analysis found that e-cigarettes contain carcinogens and toxic chemicals such as diethylene glycol, an ingredient used in antifreeze. Because there is little control or regulation of e-cigarette products, the amount of nicotine inhaled with each "puff" may vary substantially, and testing of sample cartridges found that some labeled as nicotine-free in fact had low levels of nicotine.[13] Users can refill their own cartridges with much higher doses of nicotine, and the devices can also be filled with other harmful substances. For example, instructions for filling cartridges with marijuana hash oil can be easily accessed on the Internet.[14]

The use of e-cigarettes makes it difficult for business owners and officials to enforce existing smoke-free air laws.[15] Their close resemblance to traditional cigarettes may cause confusion and lead people to believe that it is legal to smoke in smoke-free environments. Additionally, some e-cigarettes designed to look like everyday items, such as pens and USB memory sticks[16], make it easy for youth to disguise these products in schools and other settings.

Public health experts have expressed concern that e-cigarettes may increase nicotine addiction and tobacco use in young people.[17] E-cigarettes may be particularly appealing to youth due to their high-tech design, wide array of available flavors, including candy- and fruit-flavored cartridges, and easy availability online and in shopping malls.[18] Because they are not taxed as tobacco products, e-cigarettes may be more easily obtained by price-sensitive youth.

There is strong public support for regulation of e-cigarettes, according to the University of Michigan C.S. Mott Children's Hospital National Poll on Children's Health. Among the findings, 85 percent of U.S. adults favored prohibiting the sale of e-cigarettes to minors, and 91 percent supported requiring manufacturers to test e-cigarettes for safety.[19]

Various federal, state, and local regulations are in place or are being considered to restrict e-cigarette use and sales. Amtrak has banned the use of electronic smoking devices, such as e-cigarettes, on trains, in stations, and in any area where smoking is prohibited.[20] In a memorandum, the Air Force Surgeon General warned about safety concerns regarding electronic cigarettes and placed them in the same category as tobacco products.[21] Currently, the U.S. Department of Transportation is proposing a regulation that would ban the use of e-cigarettes on aircraft by clarifying that the use of e-cigarettes is prohibited as tobacco products are

prohibited.[22] Several state and local government have taken steps to limit e-cigarette use in public places and prohibit the sale of e-cigarettes to minors.[23]

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Record of Action

Submitted by Community Health Committee
Approved by NACCHO Board of Directors
March 2012

E-Cigarettes

Frequently Asked Questions and Answers about Electronic Cigarettes

What is an E-Cigarette?
An E-cigarette is a battery-operated device that generally contains liquid cartridges filled with nicotine, flavors, and other chemicals. They turn nicotine, which is a highly addictive substance, into a vapor that is inhaled by the user. Some of the cartridges claim not to contain nicotine. E-cigarettes are not regulated.

Are E-Cigarettes allowed in public places like restaurants and bars?
E-cigarettes produce a vapor instead of smoke (i.e. airborne contaminants caused by burning). Because the state's Smoking in Public Places Law only covers tobacco products that produce second-hand smoke, the E-cigarette is not covered by the law. If future research shows that the emitted vapor is harmful, it is possible that steps will be taken to include E-cigarettes in the state law. The current law does not restrict E-cigarette use in public places, but does not grant E-cigarette users the right to use them. Thus, restaurants, bars, and other locations which have a code of conduct for their customers or guests, may choose to prohibit E-cigarettes in their facilities.

Are E-Cigarettes safe to smoke?
The Food and Drug Administration (FDA) analyzed the ingredients in a small number of cartridges from two leading brands of E-Cigarettes. The results found the presence of a chemical used in antifreeze that is toxic to humans, and in several other samples, the FDA analysis detected chemicals known to cause cancer. One of the primary concerns is that these devices contain nicotine, which is a very addictive substance. There is not enough research on E-cigarettes to conclude they are safe or to conclude they are harmful. However, E-cigarettes are a nicotine delivery device, therefore, a conservative position would be that the nicotine in E-cigarettes is addictive and would likely be unsafe, but no one knows for sure.

Who can buy E-Cigarettes?
There are currently no legal restrictions on who can purchase these devices. Because of the addictive nature of nicotine, some E-cigarette vendors have chosen to refrain from selling to minors or to non-smokers.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

SESSION LAW 2013-165
SENATE BILL 530

AN ACT TO PROHIBIT THE DISTRIBUTION OF TOBACCO-DERIVED PRODUCTS AND VAPOR PRODUCTS TO MINORS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 14-313 reads as rewritten:

"Article 39.

"Protection of Minors.

"**§ 14-313. Youth access to tobacco ~~products.~~products, tobacco-derived products, vapor products, and cigarette wrapping papers.**

(a) Definitions. – The following definitions apply in this section:

(1) Distribute. – To sell, furnish, give, or provide tobacco products, including tobacco product ~~samples,~~ samples or cigarette wrapping ~~papers~~ papers, to the ultimate consumer.

(2) Proof of age. – A drivers license or other photographic identification that includes the bearer's date of birth that purports to establish that the person is 18 years of age or older.

(3) Sample. – A tobacco product distributed to members of the general public at no cost for the purpose of promoting the product.

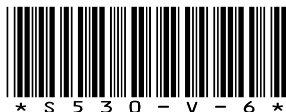
(3a) Tobacco-derived product. – Any noncombustible product derived from tobacco that contains nicotine and is intended for human consumption, whether chewed, absorbed, dissolved, ingested, or by other means. This term does not include a vapor product or any product regulated by the United States Food and Drug Administration under Chapter V of the federal Food, Drug, and Cosmetic Act.

(4) Tobacco product. – Any product that contains tobacco and is intended for human consumption. For purposes of this section, the term includes a tobacco-derived product, vapor product, or components of a vapor product.

(5) Vapor product. – Any noncombustible product that employs a mechanical heating element, battery, or electronic circuit regardless of shape or size and that can be used to heat a liquid nicotine solution contained in a vapor cartridge. The term includes an electronic cigarette, electronic cigar, electronic cigarillo, and electronic pipe. The term does not include any product regulated by the United States Food and Drug Administration under Chapter V of the federal Food, Drug, and Cosmetic Act.

(b) Sale or distribution to persons under the age of 18 years. – If any person shall distribute, or aid, assist, or abet any other person in distributing tobacco products or cigarette wrapping papers to any person under the age of 18 years, or if any person shall purchase tobacco products or cigarette wrapping papers on behalf of a ~~person, less than~~person under the age of 18 years, the person shall be guilty of a Class 2 misdemeanor; provided, however, that it shall not be unlawful to distribute tobacco products or cigarette wrapping papers to an employee when required in the performance of the employee's duties. Retail distributors of tobacco products shall prominently display near the point of sale a sign in letters at least five-eighths of an inch high which states the following:

N.C. LAW STRICTLY PROHIBITS



THE PURCHASE OF TOBACCO ~~PRODUCTS~~PRODUCTS, TOBACCO-DERIVED PRODUCTS, VAPOR PRODUCTS, AND CIGARETTE WRAPPING PAPERS.

BY PERSONS UNDER THE AGE OF 18.

PROOF OF AGE REQUIRED.

Failure to post the required sign shall be an infraction punishable by a fine of twenty-five dollars ($25.00) for the first offense and seventy-five dollars ($75.00) for each succeeding offense.

A person engaged in the sale of tobacco products or cigarette wrapping papers shall demand proof of age from a prospective purchaser if the person has reasonable grounds to believe that the prospective purchaser is under 18 years of age. Failure to demand proof of age as required by this subsection is a Class 2 misdemeanor if in fact the prospective purchaser is under 18 years of age. Retail distributors of tobacco products or cigarette wrapping papers shall train their sales employees in the requirements of this law. Proof of any of the following shall be a defense to any action brought under this subsection:

(1) The defendant demanded, was shown, and reasonably relied upon proof of age in the case of a retailer, or any other documentary or written evidence of age in the case of a nonretailer.
(2) The defendant relied on the electronic system established and operated by the Division of Motor Vehicles pursuant to G.S. 20-37.02.
(3) The defendant relied on a biometric identification system that demonstrated (i) the purchaser's age to be at least the required age for the purchase and (ii) the purchaser had previously registered with the seller or seller's agent a drivers license, a special identification card issued under G.S. 20-377.7, a military identification card, or a passport showing the purchaser's date of birth and bearing a physical description of the person named on the card.

(b1) ~~Vending machines.~~Distribution of tobacco products. – Tobacco products shall not be distributed in vending machines; provided, however, vending machines distributing tobacco products are permitted (i) in any establishment which is open only to persons 18 years of age and older; or (ii) in any establishment if the vending machine is under the continuous control of the owner or licensee of the premises or an employee thereof and can be operated only upon activation by the owner, licensee, or employee prior to each purchase and the vending machine is not accessible to the public when the establishment is closed. The owner, licensee, or employee shall demand proof of age from a prospective purchaser if the person has reasonable grounds to believe that the prospective purchaser is under 18 years of age. Failure to demand proof of age as required by this subsection is a Class 2 misdemeanor if in fact the prospective purchaser is under 18 years of age. Proof that the defendant demanded, was shown, and reasonably relied upon proof of age shall be a defense to any action brought under this subsection. Vending machines distributing tobacco products in establishments not meeting the above conditions shall be removed prior to December 1, 1997. Vending machines distributing tobacco-derived products, vapor products, or components of vapor products in establishments not meeting the above conditions shall be removed prior to August 1, 2013. Any person distributing tobacco products through vending machines in violation of this subsection shall be guilty of a Class 2 misdemeanor.

(b2) Internet distribution of tobacco products. – A person engaged in the distribution of tobacco products through the Internet or other remote sales methods shall perform an age verification through an independent, third-party age verification service that compares information available from public records to the personal information entered by the individual during the ordering process to establish that the individual ordering the tobacco products is 18 years of age or older.

(c) Purchase by persons under the age of 18 years. – If any person under the age of 18 years purchases or accepts receipt, or attempts to purchase or accept receipt, of tobacco products or cigarette wrapping papers, or presents or offers to any person any purported proof of age which is false, fraudulent, or not actually his or her own, for the purpose of purchasing or receiving any tobacco product or cigarette wrapping papers, the person shall be guilty of a Class 2 ~~misdemeanor.~~misdemeanor; provided, however, that it shall not be unlawful for an

employee to purchase or accept receipt of tobacco products or cigarette wrapping papers when required in the performance of the employee's duties.

(d) ~~Send or assist~~Sending or assisting a person ~~less than~~ 18 years to purchase or receive tobacco ~~product.~~products or cigarette wrapping papers. – If any person shall send a person less than 18 years of age to purchase, acquire, receive, or attempt to purchase, acquire, or receive tobacco products or cigarette wrapping papers, or if any person shall aid or abet a person who is less than 18 years of age in purchasing, acquiring, or receiving or attempting to purchase, acquire, or receive tobacco products or cigarette wrapping papers, the person shall be guilty of a Class 2 misdemeanor; provided, however, persons under the age of 18 may be enlisted by police or local sheriffs' departments to test compliance if the testing is under the direct supervision of that law enforcement department and written parental consent is provided; provided further, that the Department of Health and Human Services shall have the authority, pursuant to a written plan prepared by the Secretary of Health and Human Services, to use persons under 18 years of age in annual, random, unannounced inspections, provided that prior written parental consent is given for the involvement of these persons and that the inspections are conducted for the sole purpose of preparing a scientifically and methodologically valid statistical study of the extent of success the State has achieved in reducing the availability of tobacco products to persons under the age of 18, and preparing any report to the extent required by section 1926 of the federal Public Health Service Act (42 USC § 300x-26).

(e) Statewide uniformity. – It is the intent of the General Assembly to prescribe this uniform system for the regulation of tobacco products and cigarette wrapping papers to ensure the eligibility for and receipt of any federal funds or grants that the State now receives or may receive relating to the provisions of G.S. 14-313. To ensure uniformity, no political subdivisions, boards, or agencies of the State nor any county, city, municipality, municipal corporation, town, township, village, nor any department or agency thereof, may enact ordinances, rules or regulations concerning the sale, distribution, display or promotion of (i) tobacco products or cigarette wrapping papers on or after September 1, ~~1995.~~1995, or (ii) tobacco-derived products or vapor products on or after August 1, 2013. This subsection does not apply to the regulation of vending machines, nor does it prohibit the Secretary of Revenue from adopting rules with respect to the administration of the tobacco products taxes levied under Article 2A of Chapter 105 of the General Statutes.

(f) Deferred prosecution. – Notwithstanding G.S. 15A-1341(a1), any person charged with a misdemeanor under this section shall be qualified for deferred prosecution pursuant to Article 82 of Chapter 15A of the General Statutes provided the defendant has not previously been placed on probation for a violation of this section and so states under oath."

SECTION 2. Nothing in this act shall be construed to affect the taxation of tobacco products, tobacco-derived products, vapor products, or components of a vapor product.

SECTION 3. If any provision of this act or its application is held invalid, the invalidity does not affect other provisions or applications of this act that can be given effect without the invalid provisions or applications, and to this end the provisions of this act are severable.

SECTION 4. This act becomes effective August 1, 2013, and applies to offenses committed on or after that date.

In the General Assembly read three times and ratified this the 13th day of June, 2013.

s/ Daniel J. Forest
President of the Senate

s/ Thom Tillis
Speaker of the House of Representatives

s/ Pat McCrory
Governor

Approved 4:28 p.m. this 19th day of June, 2013

BEFORE THE BOARD OF HEALTH
SPOKANE REGIONAL HEALTH DISTRICT

RESOLUTION #10-05

RE: **Support and Encourage Restricting the Sale and Distribution of Electronic Cigarettes to Minors, Use of Electronic Cigarettes by Minors**

This measure would request that jurisdictions in Spokane County adopt policies prohibiting the sale and distribution of electronic cigarettes and their component parts to minors.

WHEREAS, electronic cigarettes are rechargeable, battery-operated drug delivery devices that look similar to cigarettes and allow the user to inhale a smokeless vapor often containing nicotine; Electronic cigarettes are also known as e-cigarettes, e-cigs, vapors, electronic nicotine delivery systems and ENDS; and

WHEREAS, electronic cigarettes and their component liquids are not regulated by any government agency, including the U.S. Food and Drug Administration (FDA), and therefore there is no assurance that the product or its components are safe.

WHEREAS, the chemical nicotine is classified as a drug due to its stimulative, sedative and addictive qualities; and

WHEREAS, extended exposure to nicotine results in tolerance, requiring escalating doses of the drug to receive the desired stimulation; and

WHEREAS, withdrawal symptoms from nicotine include cognitive and attention defects, cravings, inability to sleep, and sleep disturbance; and

WHEREAS, the known clinical trials and studies related to electronic cigarettes are limited and thus is additional cause for concern regarding safety; and

WHEREAS, minors who have never smoked, and other nicotine-naïve minors, may be drawn to the uniqueness of the electronic cigarette and its liquid "flavors," and may become addicted to nicotine.

WHEREAS, electronic cigarette producers market their product to children by utilizing shopping mall kiosks and locations frequented by children; and

WHEREAS, these marketing efforts tout unsubstantiated claims, which is similar to previous attempts to entice children to use nicotine products.

WHEREAS, a study published in the Journal of the National Cancer Institute found that teens were more likely to be influenced to smoke by cigarette marketing than by peer pressure[1]. Similarly, a study published in the Journal of the American Medical Association found that as much as one-third of underage experimentation with smoking was attributable to tobacco company marketing efforts[2]; and

WHEREAS, electronic cigarettes and related marketing efforts may increase the number of young smokers; and

WHEREAS, even though they have the authority, no jurisdiction in Spokane County currently restricts the sale of electronic cigarettes (or component parts) to minors.

WHEREAS, it is in the best interest of Spokane County jurisdictions to protect children from these products.

NOW, THEREFORE, BE IT RESOLVED that the Spokane Regional Health District Board of Health supports and encourages the jurisdictions in Spokane County to adopt ordinances that

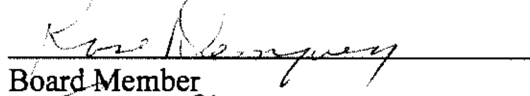
1. prohibit the
   - sale and distribution of electronic cigarettes and their component parts to minors,
   - marketing of electronic cigarettes and their component parts to minors,
   - use of electronic cigarettes and their component parts by minors,
   - unsubstantiated claims by retailers about electronic cigarettes and their component parts and
2. facilitate the effective enforcement of the aforementioned prohibitions regarding electronic cigarettes and their component parts.

Further, the Spokane Regional Health District Board of Health supports and encourages the jurisdictions in Spokane County to seek advice from the Spokane Regional Health District staff when scripting ordinances regarding electronic cigarettes and their component parts

Signed this 23rd day of September, 2010 in Spokane, Washington.

SPOKANE REGIONAL HEALTH DISTRICT BOARD OF HEALTH

Board Member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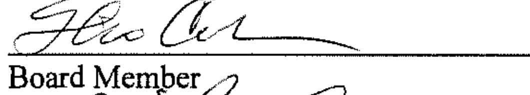
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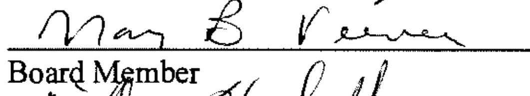
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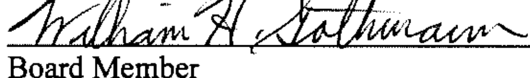
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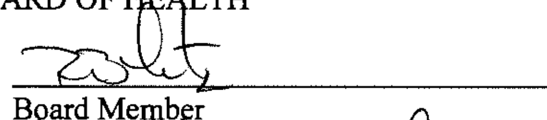
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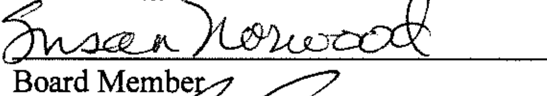
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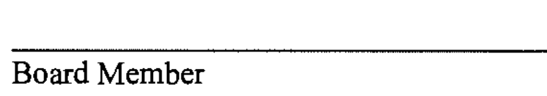
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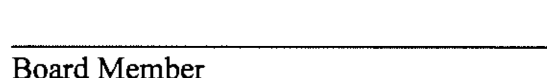
Board Member

[1] Evans N, et al., "Influence of Tobacco Marketing and Exposure to Smokers on Adolescent Susceptibility to Smoking," *Journal of the National Cancer Institute* 87(20):1538-1545, October 18, 1995.

[2] Pierce, JP, et al., "Tobacco Industry Promotion of Cigarettes and Adolescent Smoking," *Journal of the American Medical Association (JAMA)* 279(7):511-515, February 18, 1998.

Electronic cigarettes: Safety concerns and regulatory issues

Kristine A. Wollscheid and Mary E. Kremzner

Am J Health-Syst Pharm. 2009; 66:1740-2

Is there anything such as safe smoking? This is a claim made by manufacturers of electronic cigarettes, who promote their products as smoking alternatives. The wide availability and aggressive marketing of these products may leave health care providers and patients asking an important public health question. Are electronic cigarettes the same lethal vice through a more modern vehicle or are they a safer alternative to smoking?

Historically, tobacco products, such as conventional cigarettes, are some of the most unregulated products on the market. In 1996, the Food and Drug Administration (FDA) attempted to assert jurisdiction over tobacco products under the Food, Drug, and Cosmetic Act of 1938.[1] However, this was met by great resistance, particularly by the tobacco industry. Ultimately, the courts determined that FDA did not have legal jurisdiction over tobacco products. After this ruling, all FDA tobacco regulations were dropped (Leggett CC, Food and Drug Administration, personal communication, 2002). However, on June 29, 2009, president Obama signed the Family Smoking Prevention and Tobacco Control Act.[2] This new legislation grants FDA the authority to regulate tobacco products. The FDA is now starting to collaborate with public health leaders to develop and implement regulations.[3]

Independent of the new tobacco legislation, FDA has regulatory jurisdiction over nicotine replacement therapies and other non-nicotine-containing oral medications that are marketed as smoking-cessation aids. These medications and nicotine-containing skin patches, chewing gums, oral inhalers, and nasal sprays have demonstrated safety and efficacy through controlled clinical trials and have indications that are approved by FDA. Advertising for electronic cigarettes suggests that these products can be used as safe alternatives to conventional cigarettes, a message that may be misleading for both health care providers and patients.

Design characteristics. Although various brands of electronic cigarettes exist, most share the same general design (Figure 1). These nonflammable products are driven by microtechnology with three general components: a nicotine cartridge, an atomization chamber with a membrane to suspend the ingredients, and a smart chip with a rechargeable lithium battery.

Manufacturers claim that the product's nicotine cartridge also contains water, propylene glycol, and other ingredients (e.g., flavorings). Some products emit an aroma that emulates tobacco or other scents; others are odorless. Unlike conventional cigarettes, these products do not contain tobacco or tar. However, FDA's Division of Pharmaceutical Analysis has recently analyzed samples of two brands of electronic cigarettes. The identified ingredients include diethylene glycol (a component of antifreeze) and nitrosamine (a known carcinogen).[4] Since these results are limited to products from two companies, no one can be certain of the type and quantity of ingredients that may be found in other brands of electronic cigarettes.

The tip of the delivery device has an indicator light that turns red as you inhale. Upon inhalation, the nicotine cartridge becomes heated, and the atomization chamber creates mist that resembles the smoke from conventional cigarettes. The nicotine-containing mist is not inhaled by the user and quickly evaporates. The actual effects, including effects of secondary exposure, of the vapor are unknown. In contrast to the few named ingredients used in the electronic cigarette cartridge, the top manufacturers of conventional tobacco cigarettes reportedly use a combined total of 599 ingredients in the production process.[5]

Although most electronic cigarette products appear to be tobacco free, health care providers and pa-

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The views expressed do not necessarily represent the views of the Food and Drug Administration.

The authors have declared no potential conflicts of interest.

DOI 10.2146/ajhp090127

Figure 1. Basic design of an electronic cigarette.

tients must remember that nicotine alone is highly addictive and has been associated with adverse events. Based on product design, it appears that electronic cigarettes are intended to deliver addictive levels of nicotine, which could lead to adverse effects. Upon inhalation, nicotine is carried deep into the lungs and absorbed quickly into the bloodstream. Chronic systemic exposure to nicotine has been found to contribute to accelerated coronary artery disease, acute cardiac ischemic events, and hypertension. Other potential adverse effects of nicotine include stroke, delayed wound healing, reproductive toxicity, peptic ulcer disease, and esophageal reflux.[6]

Regulatory perspective. The electronic cigarettes that have been investigated by FDA are not subject to the Family Smoking Prevention and Tobacco Control Act.[7] Thus, they do not fit within the regulatory scheme that Congress has established for tobacco products.

FDA has indicated that electronic cigarettes are intended to be manipulated and used in ways similar to how a smoker manipulates and uses conventional cigarettes. Moreover, like conventional cigarettes, electronic cigarettes are intended primarily for the delivery of volatilized chemical substances, which often include nicotine. Since FDA is not aware of any data establishing that such products are generally recognized among scientific experts as safe and effective, these products are new drugs, as defined by the Federal Food, Drug, and Cosmetic Act of 1938,[1] requiring approval of a new drug application (NDA) to be legally marketed in the United States. Without an approved NDA, the marketing of the various brands of electronic cigarettes reviewed by FDA is subject to enforcement action within the United States.

Although general regulatory statements can be made, in order to make a definitive determination of the regulatory status of any drug and device combination product, FDA must review a complete description of the product's design, function, formulation, labeling and promotion (including statements and representations on the Internet), and any other information (e.g., patents) used to describe the product's intended uses.

FDA continues to evaluate the regulatory status of electronic cigarettes on a case-by-case basis. Although no electronic cigarette has received FDA-approved labeling, manufacturers continue to make unfounded claims. Examples of these statements include "It's a better way to smoke. It is free of tar and carbon monoxide, therefore, healthier. There is no danger of secondhand smoke."[7] Since no clinical trials have been conducted with these products, it is unclear how electronic cigarettes actually affect the body's structures and functions or if they mitigate or treat the symptoms of nicotine addiction. FDA requires all nicotine-delivery products intended for use by humans, with the exception of conventional tobacco products, to be clinically proven for safety and efficacy and regulated.

Currently, electronic cigarettes are sold in all 50 states and in over 25 other countries. They are available online and at several retail locations across the United States. It is not uncommon for unscrupulous marketers to introduce unregulated products into the market without FDA's review or approval. One of the first steps in targeting unapproved products is the issuance of an import alert, which allows for the refusal of entry of several brands of electronic cigarettes offered for importation into the United States.[8] However, with limited FDA resources and creative manufacturers who misbrand their products, some products may continue to enter the United States.

Information for health care providers. Based on consumer inquiries to FDA, electronic cigarettes appear to be viewed by the general public as an aid to smoking cessation. This misconception needs to be addressed by health care providers. The goal is to stop or prevent smoking, not to seek an unproven alternative that may delay a smoker's desire to quit or encourage the initiation of smoking behavior if a product is perceived as a safer alternative to conventional cigarettes. These products may be attractive to minors who may be drawn to the technology, flavoring, and accessibility.

Until FDA review and approval of electronic cigarettes prove otherwise, smokers should be encouraged to seek nicotine replacement therapies or non-nicotine-containing oral medications with FDA-approved labeling.

In the interest of public health, health care providers should advise patients that electronic cigarettes are not a proven, safer alternative to conventional cigarettes. For this reason, the use of these product as a harm-reduction strategy or smokeless alternative in public settings should be discouraged.

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