

## MINUTES OF THE CASWELL COUNTY BOARD OF HEALTH

The Caswell County Board of Health met at 7:00 P.M. on April 22, 2014 in the Caswell County Health Department's downstairs meeting room in Yanceyville, North Carolina.

**ATTENDANCE:**

Position	Name	Present	Not Present
County Commissioner	Nate Hall		X
Pharmacist	Andrew Foster, Pharm. D, R.Ph. (Chair)	X	
Dentist	Rose Satterfield, DMD	X	
Veterinarian	Donald Fuller, DVM		X
Physician (Gen. Pub.)	Cecil Page	X	
Registered Nurse	Jennifer White, RN	X	
Engineer (Gen. Pub.)	Ricky McVey	X	
Optometrist (Gen. Pub.)	Carl Carroll, RS, MBA		X
General Public	Keisha King		X
General Public	Elin Armeau-Claggett, PA-C, PhD (Vice-Chair)	X	
General Public	Sharon Kupit	X	

Others Present: Frederick Moore, MD – Health Director  
 Sharon Hendricks – Finance Officer  
 Jennifer Eastwood, MPH – QI Specialist  
 Patty Smith-Overman, FNP – Clinic Director

**I. Call to Order**

A. The April 22, 2014 meeting of the Caswell County Board of Health was called to order by the Chair at 7:00 P.M.

**II. Public Comment**

A. None

**III. Action Items**

A. Approval of Minutes

A motion was made by Cecil Page and seconded by Rick McVey, to approve the March 25, 2014 Minutes of the Board Of Health. The motion carried on a vote of 7 to 0.

B. Budget Amendment

1. Dr. Moore said that Budget Amendment #5 move funds from one line item to another but there was no net increase or decrease in the total Health Department budget.
2. Dr. Moore commented that as we get closer to the end of the fiscal year there is more moving of money around to cover expenses.
3. Elin Armeau-Claggett asked why there was a decrease in the salary line item. Dr. Moore said that these funds were probably available due to lapsed salaries and worm being moved to other line items to cover expenses.

A motion was made by Elin Armeau-Claggett and seconded by Cecil Page to approve Health Department Budget Amendment #5 as presented. The motion carried on a vote of 7 to 0.

C. Budget for FY 2015

1. Dr. Moore said that since the last board meeting he had held discussions with each program coordinator and gone through every program's budget line by line. This was an attempt to give each coordinator a chance to provide input into the budget and to make sure that we had the funds budgeted that were needed to meet program requirements. It also gave me staff an opportunity to express their

- wishes, not just their needs. Dr. Moore said that there were some minor changes based on these discussions but nothing too dramatic.
2. Dr. Moore said that he and Sharon Hendricks updated our budget spreadsheet to include all revenue and expenses through the end of March. This process resulted in some changes both positive and negative in our projection of revenues and expenses.
  3. We also made some minor adjustments to the amount of time some employees spend in programs to better utilize non-County dollars.
  4. We received the final figures for health insurance for next year which reduced the cost by about \$350 a year per full-time employee.
  5. We also discovered that the CareAnyware billing contract does not expire until April 1, 2015 so we needed to put some funds back into the budget to cover these expenses. Dr. Moore said that he had bought the contract expired the end of June 2014 but when he was double checking this discovered it didn't expire until April 2015. Dr. Moore said that he was upset that he had made this mistake but if there is a silver lining, it is that this delay will spread out some of the major changes that are happening this year to make them more manageable. If this delay had not happened it would have meant that we would've been going live with Patagonia EHR as well as taking on all of the home health billing at the same time and to some extent the same people would have been doing all of this work. Dr. Moore said that he would've been happier if there were a few months separating these two events rather than the eight months that are now scheduled.
  6. Dr. Moore said that we were monitoring CareAnyware billing more closely now and they seem to be paying closer attention to their job. Rick McVey asked if Dr. Moore had notified CareAnyware about the board's displeasure with the services provided. Dr. Moore said that he had several discussions and e-mails with them where he made it very clear what our intentions are. However, if we are "stuck" with them until April we need to continue working with them in a constructive manner. Rick McVey asked if it would be beneficial to speak with the County Attorney about how to get out of this contract. Dr. Moore said that might be a good idea, but we don't want them to end the contract immediately because we are not yet ready to take on those duties. Rick McVey recommended that the attorney be consulted just to see what our options are.
  7. Elin Armeau-Claggett commented that in looking at the data presented in the packet, the Accounts Receivable looked like it was doing better. Dr. Moore said that part of the reason for this was that we "wrote off" about \$88,000 of the uncollectable debt. All of this write off is not a CareAnyware issue but some of it is.
  8. Dr. Moore said that the more he looks at the data, the main problem goes back to last summer when we lost about half of our Home Health nursing staff. While there were problems before that, it was at that point that things started really getting bad. The training of new staff takes a tremendous amount of time and effort by our supervisory staff and we are just now getting to the end of this process. If our experienced staff don't have the time to review the billing in a timely fashion due to their training of new staff, we just get further behind.
  9. Elin Armeau-Claggett asked what sort of progress had been made on cross training the clinic nurses with home health nurses. Dr. Moore said that this issue has been discussed in the Board of Health meetings several times but he has not yet figured out how to accomplish this. Both Home Health and clinic nurses are very busy doing their standard jobs and adding crosstraining to their current tasks will reduce the time they have to accomplish their primary job. In addition, if it

- takes 3 to 6 months of full-time training to get a home health nurse up to speed how long will it take for someone to learn the job in just a few hours a week? Dr. Moore said that crosstraining was a good idea in theory but he was not sure how to accomplish it in the setting of home health in the clinic.
10. There was discussion about the use of nurses paid on a per visit basis. Dr. Moore said that we had some staff nurses who were paid part-time on a per visit basis but you still have to deal with the training of the nurse as well as giving them enough work to keep them interested. So, it is helpful to some extent but it is difficult to rely on it a lot.
  11. Andrew Foster commented that it may be a good idea to transition to the in-house billing as soon as possible and then work to get out of the CareAnywhere contract as early as possible. Dr. Moore said that he felt like late summer or early fall might be a good time to pursue this. Andrew Foster said we needed to keep the 60 day advance notice in mind even when terminating the contract early. Rick McVey said we needed to talk with our County Attorney well in advance of any decisions and seek his advice.
  12. There was discussion about the need for a bathroom in Environmental Health and some of the reasons why this bathroom would cost more than expected. Rick McVey said that he thought that based on the budget issues we may need to delay this project.
  13. There was a discussion about how to prioritize cuts to the health department budget and compromise our request. Dr. Moore said that he did not feel there was any fat in this budget that could easily be cut; additional cuts to the budget will reduce services. While the board felt like there were good reasons for it each of these items there was discussion about potential cuts and compromises in the following areas:
    - a. Environmental Health trucks
    - b. Environmental Health bathroom
    - c. The new part time scanning position
    - d. Breast-feeding peer counselor position
  14. Dr. Moore said that the only way to bring the health departments request down to the current year's amount used to make major cuts in personnel. The only way to make these major cuts is to eliminate programs like adult primary care and home health. This would reduce our Health Department staff by about 50% and drastically reduce the services we provide. The board felt like they were not ready to make these drastic cuts and wanted to have a called meeting of the board if it look like we're going to have to go there.
  15. There was discussion about the use of Health Department fund balance. Dr. Moore said that for the past 10 years the Board of Health as well as the previous county managers have had the discussion about the fund balance eventually drying up. There is no official requirement that the health department maintain a certain level of fund balance but it looks like this may be the year the fund balance dries up. Dr. Moore said that if our revenue picks up and the Medicaid cost settlement comes in on time this year's budget could look a lot better in a few months but we won't know what the real picture is until the end of the fiscal year. In the meantime, health department staff will continue to work as hard as they can bring in as much as they can.

A motion was made by Cecil Page and seconded by Jennifer White to approve the \$3,104,722 Health Department Budget for FY 14-15 as presented in the packet and send it on to the County Manager. The motion carried on a vote of 7 to 0.

**IV. Informational Items**

- A. Dr. Moore briefly reviewed the informational items that were included in the packet such as increasing the opportunities for students to walk to school as well as the site visitor's report from the North Carolina Local Health Department Accreditation Program.

**V. Adjournment**

- A. The Chair adjourned the meeting without objection.

**Approved By:** \_\_\_\_\_ Date \_\_\_\_\_  
Health Director

\_\_\_\_\_ Date \_\_\_\_\_  
Board of Health

**Health Director's Report – May 27, 2014**

**I. Finance**

**A. Current Year's Budget**

**1. Budget Amendment #6**

a. This amendment moves money between various line items to cover expenses and there is in addition of \$8,635 of state funds in the Environmental Health, Family Planning and Immunization programs.

**2. Budget Status (83%)**

a. Expenses: the health department has spent 75% of this year's budget.

b. Revenue: total revenue is at 68%

c. We are currently running a deficit of about \$159,000 which is an improvement over last month but we still have a ways to go to reach a balanced budget.

d. We have heard that there is a possibility that the Medicaid cost settlement of \$250,000 may get here before the end of this fiscal year but we will not know until the check arrives. If these funds do come in this fiscal year, it would make this year's budget look significantly better and it would free up some fund balance that could make next year's county contribution more reasonable.

**B. Next Year's Budget**

1. Since the board voted on the health department budget for next year I have had meetings with County manager as well as with two members of the board of commissioners. In the current proposed budget is \$2,934,771 which is about 170,000 less than the Board of Health voted on. We are still asking for \$255,000 more than the current year in county tax dollars.

2. Depending on when the Medicaid cost settlement arrives, we may be able to reduce the \$255,000 by about \$100,000. But once again this money can not be counted on until we receive it.

3. This change came from eliminating the trucks and bathroom for environmental health, eliminating the scanning position, the correction of a salary calculation error, reducing the breast-feeding peer counselor position to 40% so we are only using state dollars and a list of other smaller adjustments.

4. The proposed county budget was given to the board of commissioners a week ago and I have heard nothing specific about how the commissioners want to proceed.

**II. Miscellaneous Informational Items**

**A. Environmental Health Statistics**

**B. Clinic Visit Statistics**

**C. Information about eCigarettes**

**CASWELL COUNTY BUDGET AMENDMENT # \_\_\_\_\_**  
**Health Department Amendment # 6**

**Be it ordained,** the FY 2013-2014 Annual Budget Ordinance is hereby amended as follows:

**PUBLIC HEALTH - 5110**

<i>Expenditure Line</i>	<i>Account Code</i>	<i>Increase / (Decrease)</i>	<i>Amended Budget</i>
Salary 121	100.5110.121.000	\$13,751.00	\$1,586,152.00
Call 122	100.5110.122.000	\$1,026.00	\$45,037.00
Longevity 127	100.5110.127.000	(\$483.00)	\$22,125.00
SS / FICA 181	100.5110.181.000	\$1,603.00	\$121,954.00
Retirement 182	100.5110.182.000	\$1,071.00	\$110,894.00
Health Insurance 183	100.5110.183.000	(\$631.00)	\$212,254.00
Contracted Services 199	100.5110.199.000	(\$5,312.00)	\$502,754.00
Food & Provisions 220	100.5110.220.000	\$75.00	\$654.00
Program Supplies 230	100.5110.230.000	\$216.00	\$35,063.00
Pharmaceuticals 238	100.5110.238.000	\$2,744.00	\$41,626.00
Office Supplies 260	100.5110.260.000	(\$1,072.00)	\$11,271.00
Small Tools & Equip. 295	100.5110.295.000	\$1,409.00	\$46,090.00
Mileage 311	100.5110.311.000	(\$393.00)	\$106,415.00
Travel Subsistence 312	100.5110.312.000	\$636.00	\$6,808.00
Telephone 321	100.5110.321.000	(\$36.00)	\$11,434.00
Postage 325	100.5110.325.000	(\$143.00)	\$4,225.00
Printing 340	100.5110.340.000	(\$55.00)	\$1,409.00
Maint & Repair 352	100.5110.352.000	\$339.00	\$6,130.00
Advertising 370	100.5110.370.000	(\$104.00)	\$2,722.00
Laundry 392	100.5110.392.000	(\$88.00)	\$1,162.00
Training 395	100.5110.395.000	\$195.00	\$11,323.00
Rental of Post Meter 432	100.5110.432.000	(\$38.00)	\$612.00
Dues, Subsc. & Pub. 491	100.5110.491.000	(\$132.00)	\$20,689.00
Capital Outlay 500	100.5110.500.000	(\$5,943.00)	\$10,375.00
<b>TOTAL EXPENSE BUDGET:</b>		<b>\$8,635.00</b>	<b>\$3,120,255.00</b>

<i>Revenue Lines</i>	<i>Account Code</i>	<i>Increase / (Decrease)</i>	<i>Amended Budget</i>
State - Public Health	100.3510.360.000	\$8,635.00	\$643,965.00
<b>TOTAL REVENUE BUDGET:</b>		<b>\$8,635.00</b>	<b>\$3,120,255.00</b>

**Justification:**

Move funds between lines to cover expenses. Addition of State funds (EH F&L \$2,374 and Reinstatement of IMM funds \$3,583 and FP \$2,678)

That all Ordinances or portions of Ordinances in conflict are hereby repealed.

Approved by Health Director \_\_\_\_\_ Date \_\_\_\_\_

Approved by Board of Health \_\_\_\_\_ Date \_\_\_\_\_

Paula Seamster, Clerk to the Board \_\_\_\_\_ Date \_\_\_\_\_

**Approved by the Caswell County Board of Commissioners**

**CASWELL COUNTY HEALTH DEPARTMENT (FY 2013-2014)**

	<b>Budget</b>	<b>Actual YTD</b>	<b>Balance</b>	<b>YTD = 83.33%</b>
<b>SALARY &amp; BENEFITS SUBTOTAL</b>	<b>2,094,833.00</b>	<b>1,630,459.83</b>	<b>464,373.17</b>	<b>77.83%</b>
Board Expenses 120	0.00	0.00	0.00	0.00%
Salary 121	1,582,569.00	1,232,778.17	349,790.83	77.90%
Call 122	45,037.00	27,525.00	17,512.00	61.12%
Longevity 127	22,125.00	21,764.52	360.48	98.37%
SS / FICA 181	121,954.00	94,635.01	27,318.99	77.60%
Retirement 182	110,894.00	88,409.45	22,484.55	79.72%
Health Insurance 183	212,254.00	165,347.68	46,906.32	77.90%
<b>OPERATIONAL EXPENSE SUBTOTAL</b>	<b>1,021,839.00</b>	<b>719,696.26</b>	<b>302,142.74</b>	<b>70.43%</b>
Contracted Services 199	502,754.00	327,808.89	174,945.11	65.20%
Food & Provisions 220	654.00	420.07	233.93	64.23%
Program Supplies 230	35,063.00	20,711.78	14,351.22	59.07%
Pharmaceuticals 238	41,626.00	29,656.22	11,969.78	71.24%
HH/CAP Med Supplies 239	188,000.00	145,367.72	42,632.28	77.32%
Office Supplies 260	11,271.00	9,464.30	1,806.70	83.97%
Small Tools & Equip. 295	46,090.00	41,521.13	4,568.87	90.09%
Mileage 311	106,415.00	73,083.26	33,331.74	68.68%
Travel Subsistence 312	6,808.00	5,417.20	1,390.80	79.57%
Telephone 321	11,434.00	7,942.48	3,491.52	69.46%
Postage 325	4,225.00	3,192.92	1,032.08	75.57%
Printing 340	1,409.00	763.65	645.35	54.20%
Maint & Repair 352	6,130.00	5,376.50	753.50	87.71%
Advertising 370	2,722.00	2,362.64	359.36	86.80%
Laundry 392	1,162.00	517.53	644.47	44.54%
Training 395	11,323.00	5,532.50	5,790.50	48.86%
Rental of Copier 431	8,793.00	7,316.44	1,476.56	83.21%
Rental of Post Meter 432	612.00	612.00	0.00	100.00%
Ins & Bonding 450	4,284.00	4,283.55	0.45	99.99%
Dues, Subsc. & Pub. 491	20,689.00	17,970.48	2,718.52	86.86%
Capital Outlay 500	10,375.00	10,375.00	0.00	100.00%
<b>TOTAL EXPENSES</b>	<b>3,116,672.00</b>	<b>2,350,156.09</b>	<b>766,515.91</b>	<b>75.41%</b>
<b>TOTAL REVENUE</b>	<b>3,116,672.00</b>	<b>2,120,033.59</b>	<b>996,638.41</b>	<b>68.02%</b>
<b>STATE SUBTOTAL</b>	<b>643,965.00</b>	<b>389,276.29</b>	<b>254,688.71</b>	<b>60.45%</b>
(101) COUNTY APPROP	371,576.00	296,018.50	75,557.50	79.67%
(103) UR FUND BAL	96,042.00	84,767.04	11,274.96	88.26%
(102) WCH FUND BAL	134,923.00	132,819.77	2,103.23	98.44%
(102) PPC FUND BAL	55,081.00	38,830.44	16,250.56	70.50%
<b>OTHER SUBTOTAL</b>	<b>657,622.00</b>	<b>552,435.75</b>	<b>105,186.25</b>	<b>84.01%</b>
(102) MCD - REGULAR	970,000.00	736,379.86	233,620.14	75.92%
(102) MCD - SETTLEMENT	0.00	0.00	0.00	0.00%
(103) MCR - REGULAR	703,801.00	351,657.49	352,143.51	49.97%
(103) MCR - HMO	57,437.00	26,293.09	31,143.91	45.78%
(103) PRIVATE INS	15,047.00	13,611.76	1,435.24	90.46%
(103) DIRECT FEES	68,800.00	50,379.35	18,420.65	73.23%
<b>EARNED SUBTOTAL</b>	<b>1,815,085.00</b>	<b>1,178,321.55</b>	<b>636,763.45</b>	<b>64.92%</b>
<b>BALANCE</b>	<b>0.00</b>	<b>-230,122.50</b>		

Actual (State Revenue Added)

-158,822.42

**Caswell County Health Department Proposed Budget**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>Change</b>
	<b>FY 13-14</b>	<b>FY 14-15</b>	<b>Between</b>				
	<b>Budget</b>	<b>Draft #1</b>	<b>Draft #2</b>	<b>Draft #3</b>	<b>Draft #4</b>	<b>Draft #5</b>	<b>1 &amp; 6</b>
<b>REVENUE</b>							
<b>TOTAL STATE GRANTS</b>	<b>645,609</b>	<b>620,803</b>	<b>620,803</b>	<b>621,803</b>	<b>621,803</b>	<b>622,475</b>	<b>-23,134</b>
Medicaid	973,583	899,200	904,121	947,300	947,300	947,300	-26,283
Medicare	703,801	550,500	450,500	450,500	450,500	450,500	-253,301
MCR-HMO	57,437	35,000	35,000	35,000	35,000	35,000	-22,437
Private Ins.	15,047	17,000	17,000	18,175	18,175	18,175	3,128
Direct Fees	68,800	61,100	61,200	61,500	61,500	61,500	-7,300
County Tax Appropriation	371,576	648,010	821,468	662,419	627,419	627,419	255,843
WCH Fund Balance	184,923	157,000	156,934	156,906	156,906	152,457	-32,466
UR Fund Balance	46,042	0	0	0	0	0	-46,042
PPC Fund Balance	55,081	37,696	37,696	19,945	19,945	19,945	-35,136
<b>TOTAL NON-STATE REVENUE</b>	<b>2,476,290</b>	<b>2,405,506</b>	<b>2,483,919</b>	<b>2,351,745</b>	<b>2,316,745</b>	<b>2,312,296</b>	<b>-163,994</b>
<b>GRAND TOTAL REVENUE</b>	<b>3,121,899</b>	<b>3,026,309</b>	<b>3,104,722</b>	<b>2,973,548</b>	<b>2,938,548</b>	<b>2,934,771</b>	<b>-187,128</b>
<b>EXPENSES</b>							
Board Salary & Expenses (120)	0	0	0	0	0	0	0
Salary (121)	1,580,483	1,566,768	1,566,772	1,528,120	1,528,120	1,528,120	-52,363
On Call (122)	44,011	43,849	43,849	43,849	43,849	43,849	-162
Longevity (127)	22,643	23,052	23,051	23,052	23,052	23,052	409
SS/FICA (181)	120,995	124,983	126,055	123,098	123,098	123,098	2,103
Retirement (183)	110,427	111,769	112,772	110,127	110,127	110,127	-300
Health Insurance (185)	213,499	210,625	203,205	200,411	200,411	200,411	-13,088
Other	0	0	14,000	14,000	14,000	14,000	14,000
<b>TOTAL SALARY &amp; BENEFITS</b>	<b>2,092,058</b>	<b>2,081,046</b>	<b>2,089,704</b>	<b>2,042,657</b>	<b>2,042,657</b>	<b>2,042,657</b>	<b>-49,401</b>
Contracted Services (199)	508,066	403,809	480,009	464,640	464,640	459,891	-48,175
Food & Provisions (220)	579	350	350	350	350	350	-229
Program Supplies (230)	34,847	25,285	24,921	25,474	25,474	25,474	-9,373
Pharmaceuticals (238)	38,882	43,764	42,114	42,114	42,114	42,114	3,232
HH/CAP Medical Supplies (239)	188,000	182,000	182,000	177,132	177,132	177,132	-10,868
Office Supplies (260)	12,343	11,390	12,685	9,967	9,967	9,967	-2,376
Small Tools/Equipment (295)	44,981	16,970	16,970	8,690	8,690	8,690	-36,291
Travel Mileage (311)	106,808	95,800	88,974	96,448	96,448	96,920	-9,888
Travel Subsistence (312)	6,172	5,200	5,900	4,481	4,481	4,981	-1,191
Telephone (321)	11,470	9,400	9,700	9,700	9,700	9,700	-1,770
Postage (325)	4,368	3,930	4,130	4,130	4,130	4,130	-238
Printing (340)	1,464	1,700	1,600	1,600	1,600	1,600	136
Maintenance & Repair (352)	5,791	6,900	6,900	6,400	6,400	6,400	609
Advertising (370)	2,826	3,950	3,950	3,950	3,950	3,950	1,124
Laundry & Dry Cleaning (392)	1,250	750	750	750	750	750	-500
Training/Employee Ed. Exp. (395)	11,128	11,150	11,650	11,650	11,650	11,650	522
Rental of Copier (431)	8,793	9,500	9,000	9,000	9,000	9,000	207
Rental of Postage Meter (432)	650	650	800	800	800	800	150
Insurance & Bonding (450)	4,284	9,000	9,000	5,000	5,000	5,000	716
Dues & Subscriptions (491)	20,821	13,765	13,615	13,615	13,615	13,615	-7,206
Capital Outlay (550)	16,318	90,000	90,000	35,000	0	0	-16,318
<b>TOT. OPERATING EXPENSES</b>	<b>1,029,841</b>	<b>945,263</b>	<b>1,015,018</b>	<b>930,891</b>	<b>895,891</b>	<b>892,114</b>	<b>-137,727</b>
<b>GRAND TOTAL</b>	<b>3,121,899</b>	<b>3,026,309</b>	<b>3,104,722</b>	<b>2,973,548</b>	<b>2,938,548</b>	<b>2,934,771</b>	<b>-187,128</b>

Figures highlighted in yellow indicate a change from the previous version of the budget.

- Column #1** Current budget for FY 13-14
- Column #2** Draft #1 after first review by BOH – Removed BOH Stipend; includes EH trucks and shower.
- Column #3** Draft #2 presented to BOH – Updated rev and exp including CAW Billing, Health Ins costs, vacation payout exp for retiring employee.; approved by the BOH on 4/22/2014; BOH gave some priorities if cuts were necessary.
- Column #4** Draft #3 – Changes based on discussion with County Manager, Wendy salary; April Rev update; BFPC 40%; Jessica home visits; one truck; bathroom but no shower; eliminate scanner position
- Column #5** Draft #4 – Eliminated Environmental Health truck and bathroom
- Column #6** Draft #5 – CH changes to Dental

**ENVIRONMENTAL HEALTH MONTHLY STATISTICAL REPORT  
APRIL 2014**

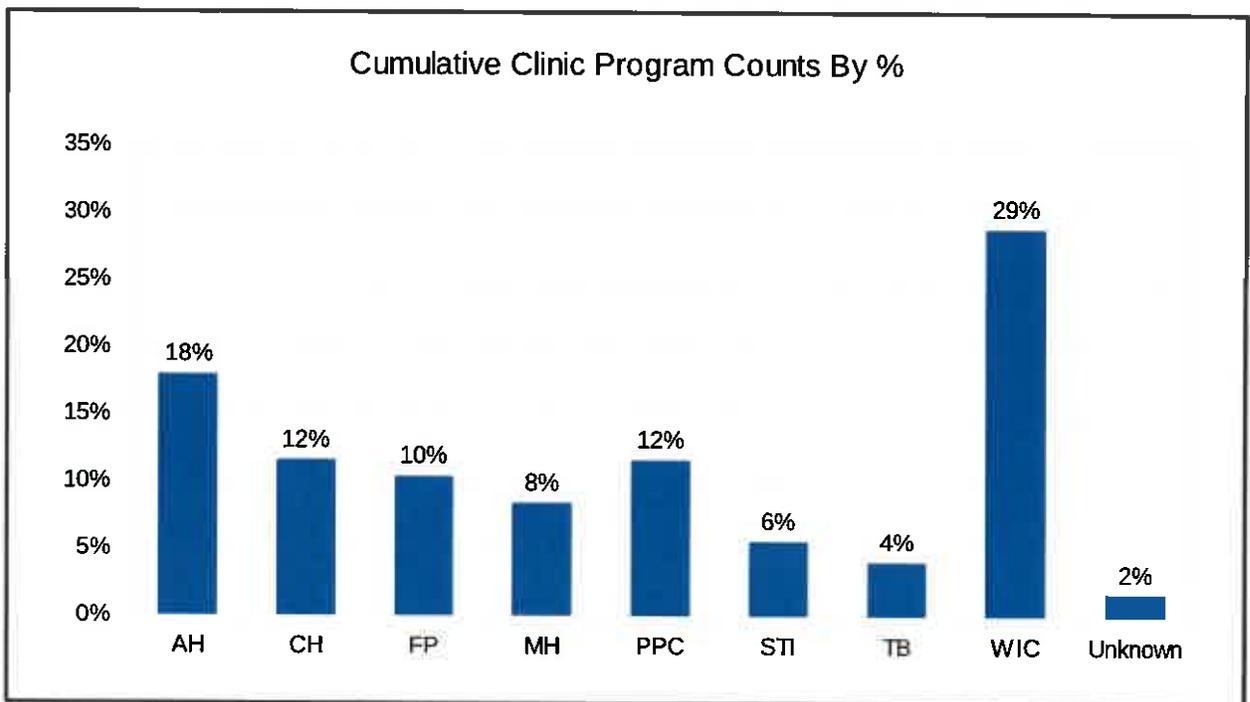
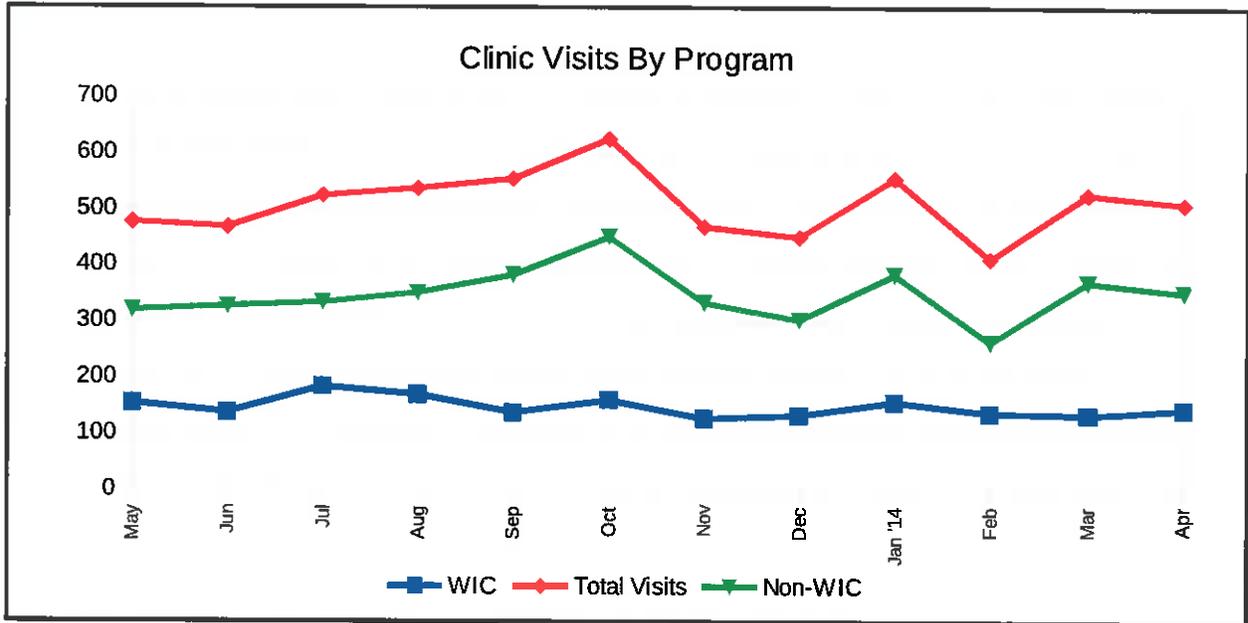
<b>ACTIVITY DESCRIPTION</b>	<b>#</b>	<b>COMMENTS</b>
<b>FOOD, LODGING, AND INSTITUTIONAL</b>		
Field Visits	21	
Inspections	12	
Permits Issued-New or Revised Business		
Permits Suspended/Revoked-Business Closed		
Food Service Plan Review	2	
Consultation Contacts	18	
Complaints	1	
<b>ON SITE WASTE WATER PROGRAM</b>		
Field Visits	86	
Soil/Site Evaluations	14	
Improvement Permits	13	
Construction Authorizations	6	
Operation Permits	14	
Denials	2	
Failing System Evaluations	4	
IP, CA, & OP Permits-Repairs	4	
Existing System Inspections/Authorizations	15	
OSWW Violations Notices	2	
Consultation Contacts	44	
Migrant Housing Inspections	5	
Pending Applications-Not Addressed		
Complaints	2	
<b>WATER SAMPLES</b>		
Field Visits	21	
Bacteria Samples	15	
Chemical Samples	4	
Petroleum Samples		
Pesticide Samples		
Nitrate/Nitrite Samples	5	
Consultation Contacts	26	
Migrant Housing Inspections	15	
<b>WELL PERMITS</b>		
Well Site Field Visits	67	
Number of Permits (New)	5	
Number of Permits(Repair)	1	
Grout Inspections	4	
Well Head Inspections	3	
Well Abandonment Inspections		
Bore Hole Camera Inspections		
Consultation Contacts	12	
Complaints		
<b>SWIMMING POOLS</b>		
Permits/Inspections		
<b>OTHER</b>		
Clerical Time (hours)	39	
Phone Contacts (Documented)	115	Office contacts (48)
Dan River Incident (Hours)	2	
Supervisors Conference	3 days	

Caswell County Environmental Health Statistics - FY 2013-2014

Service	JUL		AUG		SEP		OCT		NOV		DEC		JAN		FEB		MAR		APR		YTD TOTAL		
	#	\$	#	\$	#	\$	#	\$	#	\$	#	\$	#	\$	#	\$	#	\$	#	\$	#	\$	
Improvement Permit / Site Evaluation (< 600 gpd & less than 4 bedrooms)	4	600	1	150	7	1,050	6	900	2	300	3	450	6	900	1	150	12	1,800	5	750	47	7,050	
Improvement Permit / Site Evaluation for each additional bedroom over 3	1	75			1	75							1	75			5	375	2	150	10	750	
Improvement Permit / Site Evaluation (> 600 & < 3000 gpd)																							
Improvement Permit / Site Evaluation (> 3000 gpd)																							
New Construction Authorization & Operating Permit (Type I & II)	2	300	3	450	3	450	9	1,350	3	450	7	1,050	3	450	2	300	3	450	2	300	37	5,550	
New Construction Authorization & Operating Permit (Type III)											2	400					1	200			3	600	
New Construction Authorization & Operating Permit (Type IV)																							
New Construction Authorization & Operating Permit (Type V)																							
Expansion or Repair of OSWW Treatment System (< 600 gpd)	1	50	4	200	2	100																	
Expansion or Repair of OSWW Treatment System (> 600 & < 3000 gpd)																							
Expansion or Repair of OSWW Treatment System (> 3000 gpd)																							
Inspection of Existing OSWW Treatment System (Type I & II Addition)	3	150	1	50	3	150	4	200			4	200	2	100	1	50	1	50	1	50	20	1,000	
Inspection of Existing OSWW Treatment System (Type I & II Change Out)	1	100	2	200	6	600	1	100			3	300			2	200	4	400	2	200	21	2,100	
Inspection of Existing OSWW Treatment System (5 yr Type III Inspection)																							
Inspection of Existing OSWW Treatment System (3 yr Type IV Inspection)																							
Inspection of Existing OSWW Treatment System (Annual Type V Inspection)																							
Well Permit	5	1,500	6	1,800	6	1,800	7	2,100	8	2,400	7	2,100	6	1,800	1	300	4	1,200	5	1,500	55	16,500	
Well Camera Evaluation							1	200	1	200													
Well Repair Permit	2	400	2	400	5	1,000			1	200			1	200	1	200					12	2,400	
Bacteria Water Sample					3	150			2	100			1	50	2	100	1	50	2	100	11	550	
Chemical Water Sample	1	50			1	50			1	50	1	50					2	100			6	300	
Petroleum Water Sample			1	50																	1	50	
Pesticides Water Sample																							
Nitrate/Nitrite Sample																							
Water Sample Revisit																					1	50	
Swimming Pool Annual Permit																					1	100	
Swimming Pool Plan Review																							
Restaurant Plan Review	1	200					1	200	1	200							1	200			4	800	
Tattoo Artist Permit Annual Fee																							
Five Sample Package	1	170	1	170									1	170	1	170				1	170	5	850
Water Sample Revisit-additional test																							
Bad Check																							
Temporary Food Stand	1	75			1	75																	
Additional Charge (100.00)													1	100									
Additional Charge (50.00)																							
	23	3,670	21	3,470	38	5,500	29	5,050	19	3,900	27	4,550	25	3,995	12	1,520	38	5,025	24	3,470	256	40,150	

### Caswell County Health Dept Clinic Counts By Program And Month

Area	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan '14	Feb	Mar	Apr	Total	%
AH	85	90	85	85	90	133	78	72	85	61	93	80	2398	18%
CH	38	50	56	85	89	85	59	56	81	43	63	42	1549	12%
FP	52	64	56	44	47	57	60	48	60	37	47	61	1386	10%
MH	51	47	61	50	50	69	44	48	51	40	41	48	1122	8%
PPC	54	41	40	46	62	63	56	55	69	34	69	72	1550	12%
STI	26	31	30	28	40	30	32	22	26	30	30	26	738	6%
TB	13	3	5	12	4	13	4	1	11	18	27	24	538	4%
WIC	153	137	183	168	137	159	127	132	156	137	134	144	3858	29%
Unknown	4	4	7	18	34	15	8	16	15	11	22	12	223	2%
<b>Total Visits</b>	<b>476</b>	<b>467</b>	<b>523</b>	<b>536</b>	<b>553</b>	<b>624</b>	<b>468</b>	<b>450</b>	<b>554</b>	<b>411</b>	<b>526</b>	<b>509</b>	<b>13,362</b>	



Caswell County Health Department Clinic Counts By Zip Code And Month

Area	Zip	Jan '13	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan '14	Feb	Mar	Apr	Total	%
Alamance	27201	1											1				2	0.01%
Ashboro	27203				1												3	0.02%
Ashboro	27204																1	0.01%
Ashboro	27205				1												1	0.01%
Blanch	27212	23	20	24	14	27	22	23	30	37	32	23	32	21	24	28	653	4.87%
Bonlee	27213								1								1	0.01%
Brown Summit	27214												2				5	0.04%
Burlington	27215	2	1	2	4	2	1	1	2		1	1			1	2	40	0.30%
Burlington	27216					1											3	0.02%
Anderson	27217	22	14	35	25	20	29	22	22	30	24	17	23	23	20	20	532	3.97%
Bynum	27228								1								1	0.01%
Cedar Falls	27230											1					2	0.01%
Cedar Grove	27231																2	0.01%
Denton	27239		1									1					2	0.01%
Eagle Springs	27242											1					4	0.03%
Elon	27244	24	19	21	20	11	20	18	11	14	10	6	6	8	13	13	361	2.69%
Ether	27247								1								1	0.01%
Gibsonville	27249	14	9	13	13	8	13	5	13	15	9	6	19	5	21	15	346	2.58%
Graham	27253		2				1		1				2		1	2	16	0.12%
Haw River	27258															1	2	0.01%
Hillsborough	27278																1	0.01%
Eden	27288									1	1			2			5	0.04%
Leasburg	27291	22	19	27	18	14	21	23	27	32	14	13	24	14	14	20	487	3.63%
Lexington	27292															1	1	0.01%
Linwood, NC	27299	1															2	0.01%
McLeansville	27301								2			2		1			5	0.04%
Mebane	27302	6	13	8	13	17	10	10	17	12	7	11	13	7	8	15	267	1.99%
Milton	27305	37	42	40	32	30	29	35	57	44	37	39	40	27	41	35	1013	7.56%
Mt. Gilead	27306								1								1	0.01%
Oak Ridge	27310																1	0.01%
Pelham	27311	79	57	69	85	59	75	71	64	76	76	77	72	70	66	67	1945	14.52%
Pittsboro	27312								1				1			1	6	0.04%
Prospect Hill	27314	14	3	10	5	2	11	6	7	3	2	7	7	7	7	4	168	1.25%
Providence	27315	53	29	29	33	38	46	40	31	55	43	38	51	29	40	31	1002	7.48%
Randleman	27317																3	0.02%
Reidsville	27320	47	21	24	21	27	28	40	26	33	21	30	29	24	35	27	782	5.84%
Robbins	27325																1	0.01%
Ruffin	27326	26	24	25	14	20	26	22	23	24	26	14	27	21	20	22	587	4.38%
Sedalia	27342											2					3	0.02%
Semora	27343	12	7	7	7	5	9	13	12	12	8	8	6	7	2	3	198	1.48%
Snow Camp	27349											1					5	0.04%
Summerfield	27358																1	0.01%
Thomasville	27360															1	1	0.01%
Welcome	27374					1								1			3	0.02%
Wentworth	27375							1				1					2	0.01%
Whitsett	27377									1							2	0.01%
Yanceyville	27379	198	161	171	156	171	165	189	196	214	142	139	182	131	199	194	4600	34.33%
Greensboro	27401																1	0.01%
Greensboro	27403	1				2	1	1	1		1	1	1				11	0.08%
Greensboro	27405				1							2					5	0.04%
Greensboro	27406								1							1	4	0.03%
Greensboro	27407	1				1				3			1				11	0.08%
Greensboro	27410												1				1	0.01%
Greensboro	27455		1		1					1						1	6	0.04%
Chapel Hill	27514									1			1				2	0.01%
Chapel Hill	27516													1			1	0.01%
Hurdle Mills	27541														1		1	0.01%
Rougemont	27572	1															1	0.01%
Roxboro	27573						2		2	1							17	0.13%
Roxboro	27574	1				2		1		2		1	1			2	14	0.10%
Raleigh	27616													1		2	3	0.02%
Raleigh	27620				1		2										3	0.02%
Durham	27711					1											1	0.01%
Durham	27712																3	0.02%
Camden	27921				1												1	0.01%
Shelby, NC	28152																1	0.01%
Out Of State	*****	5	9	9	4	6	11	9	5	11	6	5	5	8	7	2	195	1.46%
Unknown		2	1	2	6	1	1		4	3		2	7	6	4		46	0.34%
<b>Total</b>		<b>592</b>	<b>453</b>	<b>516</b>	<b>476</b>	<b>466</b>	<b>523</b>	<b>536</b>	<b>553</b>	<b>625</b>	<b>465</b>	<b>444</b>	<b>554</b>	<b>414</b>	<b>524</b>	<b>510</b>	<b>13,398</b>	<b>100.00%</b>

92% Of Visits Come From The 11 Caswell County Zip Codes That Are Highlighted Above



May 13, 2014

Office on Smoking and Health  
U.S. Centers for Disease Control and Prevention  
4770 Buford Highway  
MS F-79  
Atlanta, Georgia 30341-3717

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Dear Ms. Herndon,

Per your request, I am submitting this statement of scientific evidence regarding e-cigarettes, including the health effects of e-cigarette aerosol. For the record, I am not submitting testimony for or against any specific legislative proposal.

## Introduction

E-cigarettes are part of a class of products often referred to as electronic nicotine delivery systems (ENDS), which are battery-powered devices that provide doses of nicotine and other additives to the user in an aerosol (CDC 2013). There are currently multiple types of ENDS on the U.S. market, including e-cigarettes, e-hookahs, hookah pens, vape pens, e-cigars, and others. Some of these products are disposable varieties, while other can be refilled or recharged for repeated use.

ENDS, including e-cigarettes, are currently not regulated by the U.S. Food and Drug Administration (FDA) under the Family Smoking Prevention and Tobacco Control Act, although FDA has issued a proposal to regulate them as tobacco products. Absent this federal regulation, the current landscape of ENDS—including product design and availability, sales, marketing, use, and related legislation—is one of rapid change and high variability. Significant questions remain regarding ENDS' safety and impact on patterns of conventional tobacco use. This letter summarizes the available scientific literature regarding ENDS, including surveillance data on experimentation and recent use; the health effects of ENDS, including toxicant exposure to users and non-users and impacts on patterns of conventional tobacco use; effectiveness of ENDS for quitting smoking; ENDS marketing; smokefree policies and ENDS; and evidence-based strategies to prevent and reduce tobacco use.

## ENDS use

To date, surveillance questions on the use of ENDS have focused solely on e-cigarettes. National surveys show rapid increases in adult and youth experimentation and recent use of e-cigarettes. Results from the HealthStyles survey suggest that adult e-cigarette experimentation nearly doubled from 2010 (3.3%) to 2011 (6.2%) (King, Alam et al. 2013). Data from the National Youth Tobacco Survey show experimentation doubled in U.S. middle and high school students from 2011 to 2012 (3.3% to 6.8%) and current e-cigarette use (use at least 1 day in the past 30 days) increased from 1.1% to 2.1% (CDC 2013). From 2011 to 2012, experimentation by middle school students increased from 1.4% to 2.7%, and experimentation by high school students increased from 4.7% to 10.0% (CDC 2013). In 2012, approximately 1.8 million students in grades 6-12 reported ever trying an e-cigarette (CDC 2013). One in five (20.3%) middle school students who had ever used e-cigarettes in 2012 reported that they had never used conventional cigarettes (CDC 2013). These surveillance data indicate that the majority of adults and youth who use e-cigarettes also use conventional cigarettes (CDC 2013, King, Alam et al. 2013).

## Health effects of ENDS

A discussion of the health effects of ENDS should consider the consequences of toxicant exposure for ENDS to both users and non-users, as well as potential impacts on patterns of use of other tobacco products.

### I. Toxicant exposure to users

Since ENDS are not yet regulated as tobacco products under the Tobacco Control Act, we have very little information about the ingredients of liquids (purity, impurities or stability), or the approximate exposure to harmful and potentially harmful constituents when using electronic cigarettes over the short-term or long-term. To date, manufacturers are not required to publish what chemicals are in the ENDS solution, or to perform or reveal results from systematic testing. Studies have demonstrated wide variability in design, operation, and contents and emissions of carcinogens, other toxicants, and nicotine from ENDS (DHHS 2014). Depending on the brand, ENDS cartridges typically contain nicotine, a component to produce the aerosol (e.g., propylene glycol or glycerol), and flavorings (e.g., fruit, mint, or chocolate) (Cobb, Byron et al. 2010). Potentially harmful constituents also have been documented in some ENDS, including: irritants, toxins that can change genes, and other ingredients that have been shown to cause cancer in animals (Cobb, Byron et al. 2010).

Although nicotine exposure in the absence of combustion is less hazardous than exposure to combusted conventional tobacco products (Goniewicz, Knysak et al. 2014, DHHS 2010), nicotine itself is not without risk. Nicotine is addictive (DHHS 2014). Pregnant women can transfer nicotine to their developing fetus, which can be toxic (DHHS 2014). The evidence is also suggestive that nicotine exposure during adolescence may have lasting adverse consequences for brain development (DHHS 2014). For non-smokers, nicotine is an acute irritant, potentially causing headache, nausea, and discomfort; for former smokers, nicotine exposure can trigger cravings jeopardizing their abstinence (Benowitz 1986, Panel 2008).

Because of the risks associated with nicotine, the 2014 Surgeon General's Report concluded that "the evidence is sufficient to provide cautionary messages to pregnant women and women of reproductive age as well as adolescents about the use of nicotine-containing products such as [...] electronic cigarettes, and newer forms of nicotine-containing tobacco products, as alternatives to smoking" (DHHS 2014 p. 126).

## **II. Toxicant exposure to non-users**

The health effects of ENDS may not be limited to users (Schripp, Markewitz et al. 2013, Williams, Villarreal et al. 2013, Zhang, Sumner et al. 2013). ENDS aerosol is not "water vapor." It contains nicotine and can contain additional toxins (Goniewicz, Kuma et al. 2013), and thus, it is not as safe as clean air. Although some ENDS have been shown to emit volatile organic compounds and dangerous toxins such as acetaldehydes, including acrolein, these are generally emitted at much lower levels than by cigarettes (Goniewicz, Knysak et al. 2014). However, because there are hundreds of manufacturers and no manufacturing standards, there is no way to ensure that all ENDS have acceptably low levels of toxicants.

While FDA regulation may eventually establish product standards to limit dangerous chemicals currently found in some ENDS, all ENDS have the potential to involuntarily expose children and adolescents, pregnant women, and non-users to aerosolized nicotine.

## **III. Additional hazards**

ENDS use can result in accidents and other potential health hazards. CDC recently reported that the number of calls to poison centers in the 50 states, the District of Columbia, and U.S. territories involving e-cigarettes rose from one per month in September 2010 to 215 per month in February 2014, and 51.1% of e-cigarette-related poisonings were among young children ages 0-5 (CDC 2014). In the U.S., e-cigarettes account for a small proportion of total tobacco product sales, but were involved in nearly 42% of combined monthly cigarette and e-cigarette poison center calls in February 2014. Health-care providers; the public health community; e-cigarette manufacturers, distributors, sellers, and marketers; and the public should be aware that e-cigarettes have the potential to cause acute adverse health effects and represent an emerging public health concern.

An increasingly popular method of ENDS use is to self-mix the e-liquid—both the nicotine content and the flavorings—prior to use. In this way, individuals can produce a customized ENDS product. There are also reports in the news media about the potential for e-cigarettes to be altered to deliver other psychoactive substances such as THC, the active ingredient in marijuana (CBS Los Angeles 2014, Welch 2014). Importantly, the health risks of secondhand exposure to such self-mixed concoctions are unknown.

## **IV. Impact of ENDS on patterns of tobacco use**

There are a range of potential beneficial and harmful impacts of ENDS on patterns of use of cigarettes and other combusted tobacco products. The Surgeon General has dubbed cigarettes and other combusted tobacco products the "overwhelming cause [of] the burden of death and disease from tobacco use in the United States" and recommends that "rapid elimination of their use will dramatically reduce this burden" (DHHS 2014 p. 4). The 2014 Surgeon General's Report notes that ENDS – in combination with rigorous surveillance and aggressive strategies to end combusted tobacco use – could help complement "end game" strategies to eliminate combusted tobacco use by allowing complete nicotine substitution among cigarette smokers (DHHS 2014).

In the current context, cigarettes and other combusted tobacco products are widely available, heavily marketed, inexpensive, and appealing to young people (DHHS 2014). In fact, more youth and young adults tried a cigarette for the first time in 2012 than in 2002 (DHHS 2014, Executive Summary p. 13). In this context of widespread marketing and availability of cigarettes and other combustible tobacco products, there are a number of potential adverse consequences of ENDS on tobacco use patterns (DHHS 2014). Among youth, risks include: (1) aforementioned concerns about nicotine addiction and consequences of nicotine on brain development, (2) initiation of the use of cigarettes or other combusted tobacco products as a result of introduction to inhalation of nicotine delivered via e-cigarettes, (3) exposure to e-cigarette marketing and use that normalizes a behavior that looks very similar to smoking, and (4) use of combusted and noncombustible tobacco products at the same time (“dual use”) (King, Alam et al. 2013, DHHS 2012, DHHS 2014). The potential for ENDS to renormalize tobacco use is of concern, because adolescents are particularly vulnerable to visual cues to smoke and to social norms (DHHS 2012). To advance the public health goal of preventing youth initiation of tobacco use, youth should not be able to purchase or be exposed to marketing for any tobacco products, including ENDS (DHHS 2012).

Among adults, potential adverse consequences include: (1) initiation of nicotine addiction among non-tobacco users and potential for progression to combusted tobacco use; (2) long-term dual use among current smokers, which may result in delayed quitting; and (3) relapse of smoking among former smokers (DHHS 2014).

As noted above, current evidence shows that the majority of adults and youth who are using e-cigarettes are also using conventional cigarettes (CDC 2013, King, Alam et al. 2013). This is of concern because only cutting down on the number of cigarettes smoked does not significantly reduce tobacco-related health risks (Godtfredsen, Holst et al. 2002, Tverdal and Bjartveit 2006).

### **Evidence of effectiveness for quitting smoking**

To date, no ENDS, including e-cigarettes, have been approved as a smoking cessation aid by the Food and Drug Administration’s Center for Drug Effectiveness Research (CDER) (2008 PHS Guideline Update Panel 2008), and there is very limited research on their effectiveness as a cessation aid. Several population-level longitudinal studies suggest that e-cigarette users are not more likely to quit smoking cigarettes than non-users (Grana, Popova et al. 2014, Bullen et al. 2013). Currently, seven FDA-approved prescription and non-prescription smoking cessation products are available, including nicotine replacement therapies. These products have been scientifically shown to be effective for smoking cessation, and are safe when used as directed. ENDS manufacturers have the option to apply to the FDA Center for Drug Effectiveness Research for approval to market their products as a cessation aid.

### **ENDS marketing**

Although conventional tobacco products have been banned from television advertising since 1971, ENDS are now marketed on television and other mainstream media channels. Like the products themselves, marketing claims for ENDS vary widely. The 2014 Surgeon General’s Report observed that ENDS marketing “has included claims of safety, use for smoking cessation, and statements that they are exempt from clean air policies that restrict smoking” (DHHS 2014 p. 780). Moreover, some ENDS marketing uses tactics which the Surgeon General has found lead to youth smoking (DHHS 2012): candy-flavored products; youth-resonant themes such as rebellion, glamour, and sex; and celebrity endorsements and sports and music sponsorships. This is of concern because the Surgeon General has found that “many changes in tobacco product form and marketing have been documented as efforts by the tobacco industry to contribute to tobacco use

and addiction by fostering initiation among young people; making products easier and more acceptable to use; making and marketing products so as to address health concerns; and making and marketing products to perpetuate addiction through the use of alternate products, when smoking is not allowed or is socially unacceptable” (DHHS 2014 p. 784).

### **Smokefree policies and ENDS**

Secondhand smoke (SHS) exposure from burning tobacco products causes considerable disease and death, including heart disease and lung cancer in adult nonsmokers, and sudden infant death syndrome, acute respiratory infections, middle ear infections, and more severe asthma in children. Each year, SHS exposure is responsible for an estimated 42,000 deaths among U.S. nonsmoking adults (DHHS 2014). Private sector worksites, restaurants, and bars are major sources of secondhand smoke exposure for nonsmoking employees and the public (DHHS 2006). The Surgeon General has concluded that the only way to fully protect nonsmokers from SHS exposure is to prohibit smoking in all indoor areas, and that separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate SHS exposure (DHHS 2006). Comprehensive smokefree policies that prohibit smoking in all indoor areas of worksites and public places, including bars and restaurants, have been shown to significantly reduce secondhand smoke exposure (DHHS 2014).

In addition to reducing secondhand smoke exposure, comprehensive smokefree policies have been found to reduce the prevalence of tobacco use, increase the number of tobacco users who quit, and reduce tobacco use initiation among young people (DHHS 2014). Studies of 20 U.S. and 2 Canadian communities found that employees who worked in places that implemented smoke-free policies were nearly twice as likely to stop smoking as employees who worked in places that allowed smoking everywhere (Bauer, Hyland et al. 2005). Adolescents who work in smoke-free places are significantly less likely to be smokers than adolescents who work in places with no smoking restrictions or partial workplace smoking restrictions (Farkas 2000). Moreover, challenging the perception of smoking as a normal adult behavior through smoke-free policies can change the attitudes and behaviors of adolescents. This can result in reducing the number of adolescents who start smoking (Guide to Community Preventive Services 2005).

The majority of e-cigarette users also smoke cigarettes (CDC 2013, King, Alam et al. 2013). Permitting ENDS use in public places could perpetuate combusted tobacco use and, therefore, tobacco-related morbidity and mortality. For example, ENDS use in public places could make it easier for smokers to sustain their nicotine addiction in public places, without switching completely away from combusted tobacco use. There is no evidence to support any claim that policies that allow ENDS use in public places result in smokers switching to ENDS completely. Additionally, because some e-cigarettes are designed to mimic smoking (Babej 2013), allowing ENDS use in places where smoking is prohibited could complicate enforcement of smokefree policies and renormalize tobacco use. As mentioned earlier, air containing ENDS aerosol is less safe than clean air, and ENDS use has the potential to involuntarily expose children and adolescents, pregnant women, and non-users to aerosolized nicotine and, if the products are altered, to other psychoactive substances. Therefore, clean air—free of both smoke and ENDS aerosol—remains the standard to protect the health of bystanders, prevent tobacco use initiation among youth, and encourage complete smoking cessation.

## Conclusion

ENDS have a range of potential impacts on individual and population health, and significant questions remain regarding their safety and impact on patterns of tobacco use. In contrast, considerable and conclusive evidence exists on the health harms of cigarettes and other combusted tobacco products among both users and non-users. Moreover, the scientific literature supports the safety and effectiveness of FDA-approved cessation aids when used as directed.

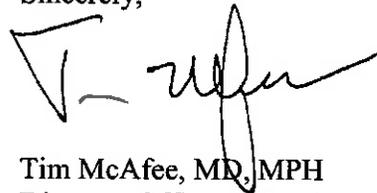
Smoking is by far the leading cause of preventable death in the U.S., causing nearly 500,000 premature deaths each year, including 42,000 deaths caused by secondhand smoke exposure (DHHS 2014). In North Carolina, 24.6% of young adults aged 18-30 are current cigarette smokers (DHHS 2014). If smoking persists at the current rate, the 2014 Surgeon General's report projects that 5.6 million of today's American children will die prematurely from a smoking-related illness, including 180,000 North Carolina youth aged 0-17 (DHHS 2014 p. 694). Considering this, the Surgeon General concluded that "the impact of the noncombustible aerosolized forms of nicotine delivery on population health is much more likely to be beneficial in an environment where the appeal, accessibility, promotion, and use of cigarettes and other combusted tobacco products are being rapidly reduced especially among youth and young adults" (DHHS 2014 p. 859).

To reduce the appeal, accessibility, promotion, and use of cigarettes and other combusted tobacco products, the 2014 Surgeon General's report recommends the following actions:

- Counteracting industry marketing by sustaining high impact national media campaigns, like CDC's "Tips from Former Smokers" campaign and FDA's youth prevention campaign, at a high frequency level and exposure for 12 months a year for a decade or more;
- Raising the average excise taxes for cigarettes to prevent youth from starting smoking and encouraging all smokers to quit;
- Fulfilling the opportunity of the Affordable Care Act to provide access to barrier-free proven tobacco use cessation treatment, including counseling and medication to all smokers, especially those with significant mental and physical comorbidities;
- Expanding smoking cessation for all smokers in primary and specialty care settings by having health care providers and systems examine how they can establish a strong standard of care for these effective treatments;
- Effective implementation of FDA's authority for tobacco product regulation in order to reduce tobacco product addictiveness and harmfulness;
- Expanding tobacco control and prevention research efforts to increase understanding of the ever changing tobacco control landscape;
- Fully funding comprehensive statewide tobacco control programs at CDC recommended levels (CDC 2014); and
- Extending comprehensive smokefree indoor protections to 100% of the U.S. population" (DHHS 2014 p. 875).

Thank you for your inquiry.

Sincerely,



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