1. Meeting Documents

Documents:

BOARD OF HEALTH REGULAR MEETING AGENDA.PDF
CHILD FATALITY TASK FORCE REPORT.PDF
CORRECTED APPROVED MINUTES OF APRIL 25, 2018.PDF
DASHBOARD REVIEW.PDF
EDITED - DRAFT MINUTES OF APRIL 25, 2018.PDF
MAY 2018 HEALTH DIRECTORS REPORT.PDF
MEDIA ITEMS.PDF
OCS CHILD NUTRITION OVERVIEW.PDF
RACIAL EQUITY COMMISSION PRESENTATION.PDF
STRATEGIC PLAN 2018 - 2020 PRESENTATION.PDF

ORANGE COUNTY BOARD OF HEALTH
MEETING AGENDA

DATE: **May 23, 2018**
TIME: **7:00 P.M.**
PLACE: **Whitted Building, 3rd Floor Meeting Room**
300 West Tryon Street
Hillsborough, NC 27278

TIME	ITEM		
7:00 p.m.	**I.**	**Welcome New Employees**	
7:00 – 7:05	**II.**	**Public Comment for Items NOT on Printed Agenda** ***public Comment for Items ON Printed Agenda will be handled during that agenda item*** (Please sign up for both on sheet near the entrance to room.) Please limit your comments to 3 minutes.	
7:05 – 7:10	**III.**	**Approval of May 23, 2018 Agenda**	
7:10 – 7:15	**IV.**	**Actions Items (Consent)**	
		A. Minutes of April 25, 2018	Susan Elmore
7:15 – 8:35	**V.**	**Educational Sessions**	
		A. Orange County Schools – Child Nutrition Overview (20 minutes) (relative to BOH Strategic Plan Priority: Physical Activity and Nutrition)	Valerie Green
		B. Child Fatality Task Force Report (15 minutes)	Pamela McCall
		C. Racial Equity Commission Presentation/Equity Summit Video (30 minutes) (relative to BOH Strategic Plan Priority: Engagement)	Beverly Scurry/Steven Campbell/Kristin Prelipp
		D. Dashboard Review (15 minutes) (relative to BOH Strategic Plan Priority: (All)	Allison Young
8:35 – 8:55	**VI.**	**Reports and Discussion with Possible Action**	
		A. Strategic Plan 2018-2020 Review (15 minutes)	Beverly Scurry
		B. Health Director Report (5 minutes)	Quintana Stewart
		C. Media Items	Kristin Prelipp
8:55 – 9:25	**VII.**	**Closed Session to Consult with Attorney** Closed Session (ref. NCGS 143-318.11(a)3) to consult with an attorney employed or retained by the public body in order to preserve the attorney-client privilege between the attorney and the public body, which privilege is hereby acknowledged.	
9:25 – 9:30	**VIII.**	**Board Comments**	
9:30	**IX.**	**Adjournment**	

BOARD MEMBERS: To ensure a quorum, SEND E-MAIL to lstrange@orangecountync.gov advising her of your attendance at this meeting OR CALL 919-245-2411.

Compliance with the "Americans with Disabilities Act" and Title VI - Interpreter services and/or special sound equipment are available on request. Call the Immigrant and Refugee Health Program Manager at 919.245.2387 to request an interpreter or other accommodation.

Conforme a la "Ley sobre Estadounidenses con Discapacidades" (ADA) y el Título VI – los servicios de intérprete y/o equipo de sonido especial están disponibles a solicitud. Llame a la Administradora del Programa de Salud para Inmigrantes y Refugiados al 919-245-2387 para solicitar un intérprete u otros arreglos o adaptaciones.

Agenda Item Number:

ORANGE COUNTY BOARD OF HEALTH
AGENDA ITEM SUMMARY

Meeting Date: May 23, 2018

Agenda Item Subject: Child Fatality Prevention Team Annual Report

Attachment(s): 2017 Child Fatality Prevention Team Annual Report

Staff or Board Member Reporting: Pam McCall

Purpose: ____ Action
_X_Information only
____Information with possible action

Summary Information: The report is a review of 2017 Orange County CFPT activities.

Recommended Action: ___Approve
___Approve & forward to Board of Commissioners for action
___Approve & forward to _____
_X_Accept as information
___Revise & schedule for future action
___Other (detail):

2017 Child Fatality Prevention Team Annual Report

I. Introduction

In 1993, the North Carolina General Assembly established a network of local Child Fatality Prevention Teams (CFPT's) across the state to confidentially review medical examiner reports, death certificates and other records of deceased residents under age 18. Each local team consists of representatives of public and nonpublic agencies in the community such as law enforcement, Guardian Ad Litem, health departments, among others, that provide services to children and their families.

The purpose of this report is to give a summary of the causes of death, the number of cases reviewed, recommendations for prevention, if any, that have been made and to share local team activities and accomplishments.

II. Role of the Orange County Commissioners and Board of Health

- Receive annual reports which contain recommendations and advocate for system improvements and needed resources, if requested.
- Appoint members of the local team as identified by the membership.

III. Child Deaths by Cause, System Problems Identified, Recommendations for Prevention & Proposed Action

In 2017, the Orange County CFPT reviewed 11 child deaths and identified 2 system problems and recommendations for future prevention efforts. Below are highlights:

Cause of Death	System Problem Identified	Recommendation	Proposed Action
hypercarbic respiratory failure due to status asthmaticus.	Child with poorly controlled asthma playing sports	More detailed sports physical form is created to identify poorly controlled asthma. Require athletic trainer for all school sports.	Medical provider on team will submit proposal for revised sports physical form to schools. CFPT will submit recommendation for required athletic trainer to school systems.
Homicide	Possible undiagnosed mental health issues.	Mental health first aid training for front line human services workers.	Mental Health First Aid Training provided September, 2017.

IV. Orange County CFPT Activities and Accomplishments

Examples:

- The annual CFPT Activity Summary was completed and sent by the date requested.
- A two-part Mental Health First Aid Training was promoted by CFPT for human service workers and community members.
- Information on multiple webinars regarding child safety issues was forwarded to team members.
- Individual reports were completed on child deaths reviewed by the team and were forwarded to the State Coordinator.

V. Conclusion

Thank you to the members of the Board of Health for the opportunity to share with you the successes and dedicated work of the local team as we continue to review child fatalities, make recommendations, and take actions to prevent future child deaths. Please feel free to contact the Chairperson at 245-2402, should you have any questions about this report.

Pam McCall, Public Health Nursing Director

Chairperson

March 19, 2018

Date

ORANGE COUNTY HEALTH DEPARTMENT MISSION STATEMENT: *To enhance the quality of life, promote the health, and preserve the environment for all people in the Orange County community.*

THE ORANGE COUNTY BOARD OF HEALTH MET ON April 25, 2018 at the Orange County Health Department, 300 West Tryon Street, Hillsborough, NC.

BOARD OF HEALTH MEMBERS PRESENT: , Timothy Smith –Vice-Chair, Bruce Baldwin Johanna Birchmayer, Paul Chelminski, Jennifer Deyo, Jessica Frega and Liska Lackey.

BOARD OF HEALTH MEMBERS ABSENT: Susan Elmore, Commissioner Mia Burroughs, Barbara Chavious and Sam Lasris.

STAFF PRESENT: Quintana Stewart, Health Director; Coby Jansen Austin, Director of Programs and Policy; Rebecca Crawford, Financial and Administrative Services Director; Victoria Hudson, Interim Environmental Health Director; Donna King, Health Promotion & Education Services Director; Kristin Prelipp, Communications Manager; Ana Salas, Dental Assistant; La Toya Strange, Administrative Assistant II; and Phil Vilaro, Interim Environmental Health Director.

GUESTS PRESENT: None

I. Welcome New Employees

Timothy Smith, Vice-Chair, called the meeting to order. There were no new employees in attendance.

II. Public Comment for Items NOT on Printed Agenda: None.

III. Approval of the April 25, 2018 Agenda

Motion was made by Jennifer Deyo to approve the agenda, seconded by Paul Chelminski and carried without dissent.

IV. Action Items (Consent)

A. Minutes of March 28, 2018 Meeting

Motion was made by Liska Lackey to approve the minutes of March 2018, seconded by Jessica Frega and carried without dissent.

V. Educational Sessions

A. Opioid Update

Board of Health member and Professor of Medicine at UNC, Dr. Paul Chelminski, gave an

excellent presentation of an overview of the national and local opioid crisis titled "Opioid Epidemic: Collisions at the Crossroads". Below are some of the highlights.

- Opioids are prescribed for moderate to severe pain, particularly chronic pain.
- Chronic pain is recognized as another important public health problem that is often undertreated.
- Key factors that led to the rise in the prescribing and consuming of opioids
  - The intent to cure pain
  - Wide acceptance that opioid painkillers were low-risk and non-addictive
  - Lack of experience in opioid addiction science
- It was learned, early on, that you can't identify a drug misuser. It's difficult to determine who is a straight shooter vs a misuser without defining unacceptable behaviors that misusers exhibit such as cocaine in urine and doctor shopping.
- The Joint Commission required physicians to ask patients to rate the amount of pain they're experiencing. This leads to the option of patient function vs pain score to determine the patient's pain level.
- The decision of whether and how providers should use opioids in a primary care setting falls largely on expert opinion and clinical judgment.
- Chronic pain has been found to be interconnected to mental illness and substance misuse of which 60-80% of people experience depression or anxiety. There is limited literature available that addresses this issue and most of it is incredibly flawed.
- Admissions for prescription opioid abuse treatment escalated more than 5 fold from 35,648 in 2001 to 180,708 in 2011.
- In 2016, the prescribing rate for opioids was 61 prescriptions per 100 persons. During this time, there was also a huge increase in opioid misuse in urban areas.
- In 2016, around 64,000 people died from drug overdoses in the U.S.
- The opioid crisis is not a Caucasian epidemic; it just started there, primarily in the Appalachian area. It then, eventually, spread to the African-American and Native American communities.
- Every 25 minutes a baby is born with opioids in their system and suffers opioid withdrawal.
- The prescribing of opioids has decreased; however, fentanyl prescription has increased. Fentanyl is 100 times more potent than opioids.
- Although opioid deaths and the prescribing began to decrease in 2010, they're starting to spike again.
- Besides public health, there are clinical and mental health dimensions to the opioid crisis.
- Some remedies to address the epidemic include naloxone, CDC guidelines, mental health reform and prescription monitor programs (PMPs).

The BOH had questions that were addressed by Dr. Chelminski.

B.&C. 3rd Quarter Billing Dashboard and Financial Reports

Rebecca Crawford, Financial & Administrative Services Director, gave a report on the 3rd quarter revenue and billing accuracy. The report is as follows:

- Total Health Department Revenue: Average YTD monthly revenue in FY18 after the third quarter is $211/month and totals $2.1M YTD, representing 61.2% of our overall budgeted revenue for the year. The total third quarter revenue is slightly skewed down due to the majority of state funds not eligible to be drawn in July (this is typical) but we

are trending higher than we were at this time last fiscal year ($1.9M). Expenses are higher than revenues at 66.2% of the total, overall budget.

- Total Billing Accuracy: Continuing with the goal of 90% billing accuracy set in FY 14-15, the average billing accuracy rate for medical after the third quarter is 89% as compared to 96% in FY 16-17 and the average rate for dental for third quarter FY 17-18 is 101% as compared to 98% in FY 16-17.

- Dental Earned Revenue by Source: The FY 17-18 average monthly revenue ($40.9/month) for the third quarter is below our budget projection ($43.4k/month) but above our FY 16-17 average of $39.8k/month. FY 17-18 dental earned revenue totaled $381k at the end of the third quarter.

- Medical Earned Revenue by Source**:** Medical earned revenue is currently below the budgeted projection for FY 17-18 ($57.1k/month) at $51.6k/month since we had a provider on maternity leave until the end of December. Medical clinic revenue totals $469k for third quarter FY 17-18.

D. Advisory Board Update

Donna King, Health Promotion and Education Services, stepped in for Beverly Scurry, Board of Health Strategic Plan Manager, and informed the Board members to email Ms. Scurry if there are any questions regarding the Advisory Board Update. She also reminded them to complete the Doodle Poll regarding subcommittee meetings. Updating the BOH Strategic Plan will be discussed. Any Board members that need help attending an REI training were encouraged to reach out to Ms. Scurry.

VI. Action Items (Non Consent)

A. Board Reappointments

Timothy Smith, Co-Chair, conveyed that there were four Board members whose term will be ending soon. The Board of Health will vote to recommend Bruce Baldwin to his 1st full term; Barbara Chavious to her 2nd full term; Timothy Smith to his 2nd full term; and Johanna Birckmayer to her 1st full term. Mr. Smith mentioned that, when voting, those that are up for reappointment, must recuse themselves.

Motion to reappoint Bruce Baldwin was made by Paul Chelminksi, seconded by Liska Lackey, and carried without dissent.

Motion to reappoint Barbara Chavious was made by Jennifer Deyo, seconded by Johanna Birckmayer, and carried without dissent.

Motion to reappoint Timothy Smith was made by Liska Lackey, seconded by Jessica Frega, and carried without dissent.

Motion to reappoint Johanna Birckmayer was made by Jessica Frega, seconded by Jennifer Deyo, and carried without dissent.

B. Fee Change

Both the Medical and Dental clinics request to add fees outside of the normal process. Rebecca Crawford reviewed those proposed fee changes which were:

Dental Clinic
The Dental Clinic was awarded a grant from Delta Dental for $2,000 and have elected to use the funding to treat childhood caries by the Silver Diamine Fluoride technique, which requires the Health Department to add an associated fee to the fee schedule. We anticipate treating 75 Medicaid eligible children between the ages of 1 and 8 during the term of the grant, which will end August 31, 2018. Based on our analysis of costs to perform the procedure and fees from surrounding jurisdictions, we propose to set the fee at $49. Given that the Medicaid reimbursement rate is $24.18 for this procedure, we only anticipate receiving $1,813.50 in revenue. The proposed change is detailed below:

Name of Fee	2017-18 Current Fee	2017-18 Proposed Fee	2017-18 Budget Impact
Silver Diamine Fluoride (D1354)	$0	$49	$1,813.50

Medical Clinic
The Medical clinic recommends this new addition to our Fee Schedule due to the recent introduction on the market of the new Shingles vaccine - Shingrix. This vaccine will keep the Orange County Health Department Clinic up to date with the newest vaccines available, it will provide the residents of Orange County with the opportunity to receive protection against the Varicella Zoster Virus and it will keep our clinic relevant and able to meet the newest federal guidelines on vaccinations of people 50 years old or above. We anticipate administering five Shingrix vaccines per year and will charge our cost to purchase the vaccine, $138.60, which would potentially result in $693 in revenue.

Name of Fee	2017-18 Current Fee	2017-18 Proposed Fee	2017-18 Budget Impact
Shingrix Vaccine (90750)	$0	$138.60	$693

The BOH members had questions that were answered by Ms. Crawford.

Motion was made by Jessica Frega to approve the proposed fee changes for 2017-2018 as presented and forward to the Board of County Commissioners for action, seconded by Paul Chelminski and carried without dissent.

VII. Reports and Discussion with Possible Action

A. Health Director Report

In addition to the report, Ms. Stewart briefly expounded upon the 3 conferences that she attended. The Annual Health Director's Public Health Legal Conference had a key presentation on the opioid crisis. Guilford County and UNC at Greensboro have created a community-engaged response to the opioid problem in which all of the agencies that deal with the opioid crisis, law enforcement, EMS, medical professionals and psychologists team up to help addicts using a unified treatment plan. Many counties want to emulate their plan.

The Equity Summit was a great conference with awesome speakers. Kristin Prelipp,

Communications Manager, is working on a presentation that will be shown to the Board members next month. Ms. Stewart presented at the National Preparedness Summit. It also gave focus to the special needs/vulnerable population which is sometimes overlooked.

Ms. Stewart also spoke briefly on the Institute of Public Health "Crafting Richer Messengers: The Public Health Advantage" workshop she attended today. She was invited by Gene Matthews, NC Institute for Public Health. There was some emphasis on how to reach non-traditional audiences and usage of more liberal type messages to help reach the conservative population.

The BOH members had questions that were answered by Ms. Stewart.

B. Media Items

Kristin Prelipp, Communications Manager, briefly mentioned the article topics of OC Health Rankings, the FSA, PrEP and ICE raids that were included in the Media Items packet. Media items were in the packet which focused on Orange County's events and our involvement in various efforts.

VIII. Board Comments

None.

IX. Adjournment

Jessica Frega moved to adjourn the meeting at 8:00pm and Paul Chelminski seconded.

The next Board of Health Meeting will be held May 23, 2018 at the Orange County Health Department, 300 West Tryon Street, Hillsborough, NC at 7:00 p.m.

Respectfully submitted,

Quintana Stewart, MPA
Orange County Health Director
Secretary to the Board

DRAFT

Agenda Item Number:

ORANGE COUNTY BOARD OF HEALTH
AGENDA ITEM SUMMARY

Meeting Date: 5-23-2018

Agenda Item Subject: Updated Dashboard Presentation

Attachment(s):

Staff or Board Member Reporting: Allison Young

Purpose: ____ Action
_X__ Information only
____ Information with possible action

Summary Information:

The OCHD Health Informatics Team presents the 2018 annual public health dashboards for Orange County. The purpose of these dashboards is to provide an executive level view of how the county is performing on indicators in major public health content areas as compared to the state, nation, peers, and available targets or goals.

There are 6 completed dashboards that make up the 2018 collection, which include the topic areas of: Substance Abuse and Mental Health (with focus areas on the Opioid Epidemic and Youth Mental Health); Chronic Disease and Obesity; Social Determinants of Health (Poverty Mitigation and Access to Care); Sexually Transmitted Infections; Maternal and Infant Health; and Injury and Violence.

The presentation will summarize key take-away findings from this year's data and plans for utilizing the dashboards to set targets and guide decision making in the coming year.

Packet includes:
1) Executive Summary of 2018 Public Health Dashboards
2) Bundle of Public Health Dashboards
3) Dashboard Companion Document (FAQ and Source Table)

Recommended Action: ___Approve
___Approve & forward to Board of Commissioners for action
___Approve & forward to _____
_X_ Accept as information
___Revise & schedule for future action
___Other (detail):

2018 Population Health Dashboards
Orange County, NC

Substance Use and Mental Health

6 of 10 measures in caution or alert zone

36%	43%	21%

Summary:
Orange County saw significant increases in both Drug Overdose and Opioid Overdose mortality rates in 2016. However, it is important to remember that as a county with a small population, sizable fluctuation in rates from year to year is not unusual. It appears on several measures (alcohol, marijuana, and smoking cigarettes or e-cigarettes), **High School substance use decreased from 2015 to 2017 (CHCCS)**. Additionally, fewer students reported that they believed vaping is low in harm. **However, more Orange County students report current marijuana use than NC or the US. Depression continues to be a common condition that close to 1 in 5 residents face, young and old.**

- Performing better than four or more benchmarks
- Performing better than two or three benchmarks
- Performing better than one or no benchmarks

Benchmarks include Previous, Peer, NC, US, and 2020 Target
OC Targets represent proposed local goals

- ↑↓ Positive trend
- ↑↓ Negative trend
- SAME No trend
- \- Trend cannot be assessed

Significant change from previous that is positive, negative, or indeterminable (grey)

Alcohol	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Adults who Drink Excessively (Binge Drinking)*	-	NA	*NA*	23%	-	NA	15%	17%	NA
% High schoolers using alcohol products (CHCCS)**	●	23%	*NA*	29%	↓	NA	29%	33%	NA
% High schoolers using alcohol products (OCS)***	-	16%	*NA*	NA	-	NA	29%	33%	NA
% Crashes that are Alcohol Related	●	4%	*5%*	5%	↓	4%	4%	5%	5%

Opioids and Drug Overdose	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% High schoolers who have used marijuana in past 30 days (CHCCS)**	◆	29%	*22%*	34%	↓	NA	22%	22%	NA
% Providers registered in CSRS	●	79%	*NA*	22%	↑	77%	NA	NA	NA
Drug Overdose Mortality Rate	▲	13	*10*	7	↑	32	19	20	NA
Opioid Overdose Mortality Rate	▲	6	*5*	4	↑	16	15	13	NA

Tobacco	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Adult Smokers*	-	NA	*13%*	17%	-	NA	18%	16%	13%
% High schoolers who smoked in past 30 days (CHCCS)**	●	17%	*16%*	21%	↓	NA	NA	31%	16%
% High schoolers who have ever used an e-cigarette (CHCCS)**	▲	29%	*25%*	37%	↓	NA	49%	45%	NA
% High schoolers who have ever used an e-cigarette (OCS)***	-	21%	*25%*	NA	-	NA	49%	45%	NA
% High schoolers who believe vape is low harm (CHCCS)**	-	56%	*NA*	65%	↓	NA	NA	NA	NA

Older Adult Mental Health	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Older Adults with Depression	◆	19%	*16%*	16%	↑	14%	18%	17%	NA
Alzheimer's Age-Adj Mortality Rate	◆	27	*25*	27	SAME	18	32	25	NA

Suicide	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Suicide Mortality Rate	●	9	*8*	9	SAME	14	13	14	8

Sources: *BRFSS (2011), CHCCS YRBS (2015, 2017), OCS YRBS (2016), SCHS Mortality statistics (2015-16) and records (2012-2016), DHHS/Highway Research Center (2015-16),* ***Rates*** *are per 100,000 unless otherwise noted.*

Data Notes:
**Due to changes in survey methodology and overlapping confidence intervals, BRFSS data cannot be compared to previous years,*
***Confidence intervals for YRBS trend data are unavailable to assess significance of trends over time*
****Sample size for OCS YRBS was small due to an active consent process and may not represent general population rates*
See the ***Public Health Dashboard FAQ Document*** *for more on data methodology.*

Opioid Use and Drug Overdose

Summary:
The drug overdose mortality rate in Orange County has increased from 5.7 deaths per 100,000 residents in 2014 to 12.6 deaths per 100,000 residents in 2016**. The rate of opioid overdose mortality has also risen from 3.6 deaths per 100,000 residents in 2014 to 6.3 per 100,000 in 2016.** The number of providers registered in the NC Controlled Substance Reporting System has risen in the past 5 years and estimated percent of providers using the system is comparable to peer counties. **Orange County saw more than 400 ED visits related to Medication/Drug poisoning in 2017.** More than a quarter of these were related to either opioids, heroin, or benzodiazepines (25.4%)

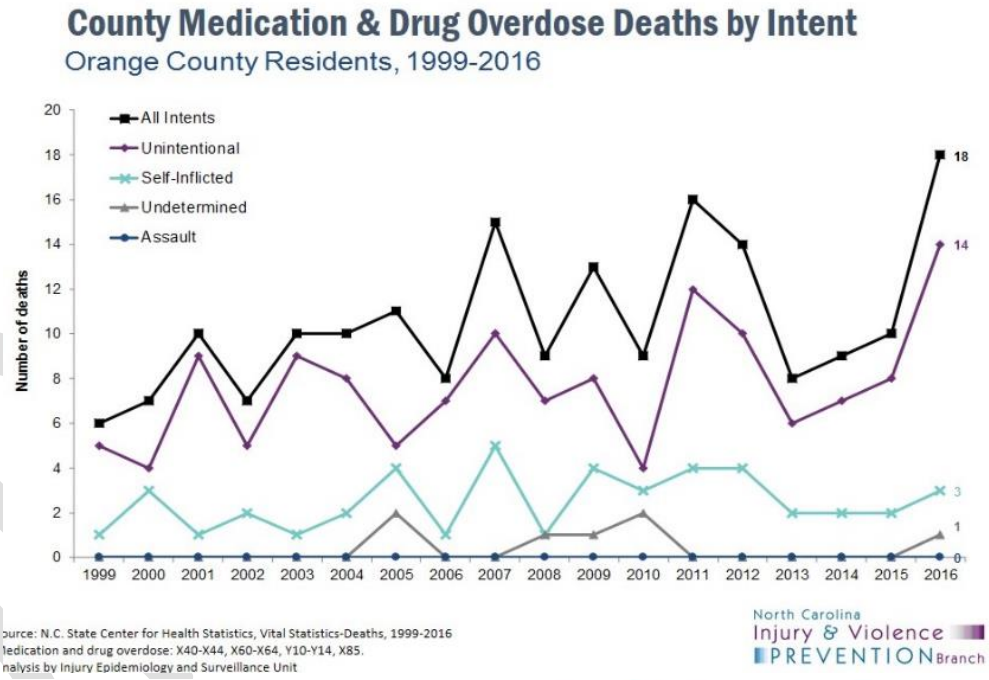
Opioids and Drug Overdose	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Providers registered in CSRS	●	79%	*NA*	22%	↑	77%	NA	NA	NA
Drug Overdose Mortality Rate	▲	13	*10*	7	↑	32	19	20	NA
Opioid Overdose Mortality Rate	▲	6	*5*	4	↑	16	15	13	NA

Sources: *SCHS Mortality statistics (2015-16) and NC Injury and Prevention Branch (2016)*

Trends show an increase in overdose deaths, and the drugs that cause them.

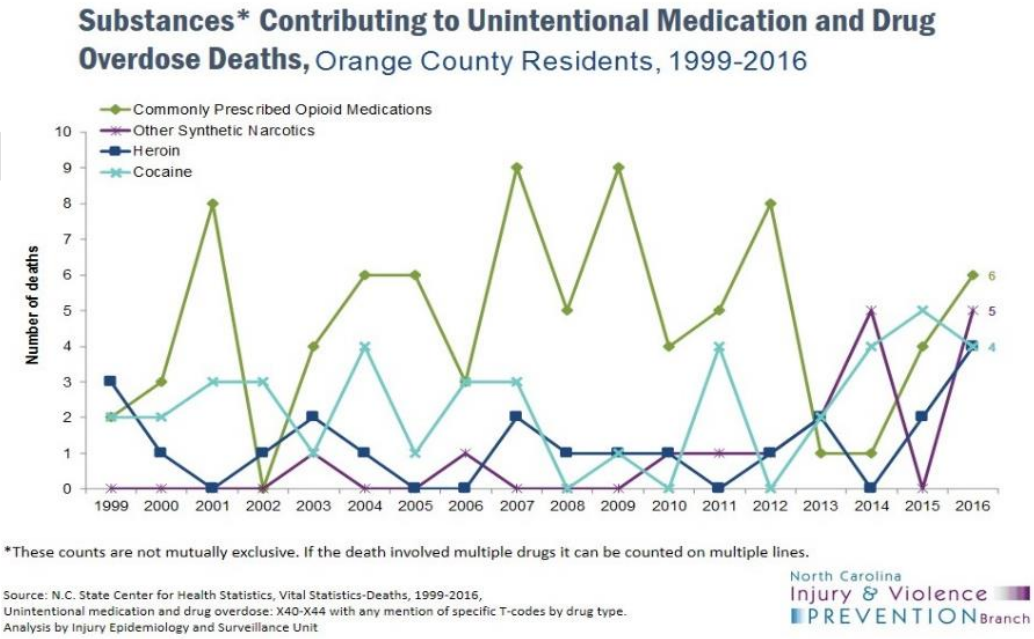
Overdose Mortality increased in 2016.

2016 data for Orange County deaths mirrors that of the state, **as drug overdose mortality showed an up-tick in 2016 (all intents).**



Prescription Opioids are not the only issue.

Opioid medications are not the only drugs showing an elevated appearance as a cause of death in the last several years. **Other synthetic narcotics, cocaine, and heroin also saw increases as contributors to overdose mortality in 2016.**



Opioid and Other Drug Prescribing

Summary:

Orange County is ranked #1 (best) in the state when it comes to the number of Opioid prescriptions (.52) or pills prescribed per resident (34.5) in 2016, which represents an average. This puts Orange County on par with the lowest quartile state averages in the US in 2014 (.52-.71). Regional neighbors are prescribing at similar rates, while we are doing slightly better than western peers (Buncombe), and much better than coastal ones (Brunswick). However, Orange County is ranked 75th on strength of Opioid prescription (54.2) per resident. This measure uses algorithms to translate all prescriptions to a single measure of MME (morphine milligram equivalents). The risk for overdose is directly associated with the use of multiple prescribers and daily dosages of >100 morphine milligram equivalents (MMEs) per day (CDC).

For Benzodiazepines, Orange County is ranked 10th at .3 Rx/resident and 15.3 pills /resident. Unlike Opioid use, which increases with age, anxiety is most prevalent in people aged 30-44, so a larger population in this age group may affect this measure (although national Rx trends do not reflect along the age trends one would expect, actually seeing an increase in benzodiazepine Rx with age). Opioid and benzodiazepine prescribing rates have been stable over the past 6 years in Orange County. However, the stimulant prescribing rate has increased from 24 prescriptions per 100 residents to 30, **placing Orange County 96th out of 100 counties.**

- Performing better than four or more benchmarks
- Performing better than two or three benchmarks
- Performing better than one or no benchmarks

Benchmarks include Previous, Peer, NC, US, and 2020 Target
OC Targets represent proposed local goals

- ↑↓ Positive trend
- ↑↓ Negative trend
- SAME No trend
- \- Trend cannot be assessed

Significant change from previous that is positive, negative, or indeterminable (grey)

Drug Prescribing Rates (2015-2016)	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Number of Opioid Prescriptions per 100 Residents	△	52	*NA*	53	SAME	92	93	NA	NA
Strength of Average Opioid Prescription (MME)	-	54	*NA*	54	SAME	52	NA	NA	NA
Number of Benzodiazepine Prescriptions per 100 Residents	△	30	*NA*	31	SAME	48	42	NA	NA
Number of Stimulant Prescriptions per 100 Residents	△	31	*NA*	30	SAME	26	27	NA	NA

Sources: *SCHS Mortality statistics (2015-16) and records (2012-2016), CSRS via NC DHHS (2015-16), CDC (2016)*

Data Considerations: *The number and strength of prescriptions are correlated with age of patient and reason for prescription. Orange County has a younger population and also has a well-recognized hospital center that performs major procedures and may attract residents with chronic health conditions. Both of these factors may impact these measures. Unlike Opioid conditions, which increase with age, anxiety is most prevalent in people aged 30-44, so a larger population in this age group may affect this (although nationally they did not see Rx trends reflect along age trends they would expect, actually seeing increase in Rx with age).*

Responding to the Opioid Epidemic

In response to the Opioid epidemic, representatives of North Carolina and public health professionals from the injury and violence prevention branch and broader health community put together the **North Carolina Opioid Action Plan. This plan, initiated in 2017, will run through 2021 and focuses on prevention, treatment, and recovery efforts to reduce mortality and morbidity related to drug use and overdose**. As stated on the DHHS website, strategies of the plan are listed below, along with updated statistics on drug overdose reversals recorded in Orange County from 2013-2017.

- Coordinating the state's infrastructure to tackle the opioid crisis.
- Reducing the oversupply of prescription opioids.
- Reducing the diversion of prescription drugs and the flow of illicit drugs.
- Increasing community awareness and prevention.
- Making naloxone widely available.
- Expanding treatment and recovery systems of care.
- Measuring the effectiveness of these strategies based on results.

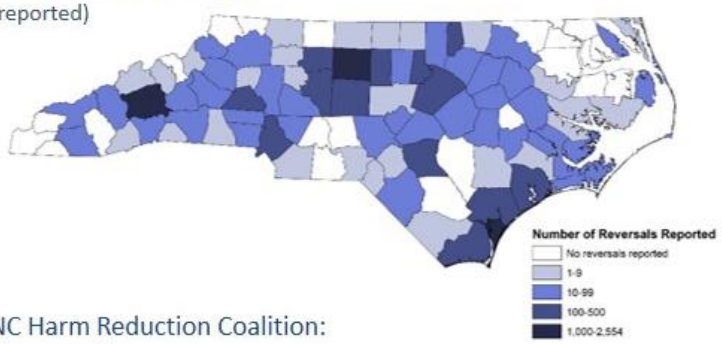
Drug Overdose Reversals and Emergency Response

Summary:
As part of an effort to reduce overdose deaths, all four Orange County branches of law enforcement carry naloxone, an overdose reversal drug, and have been trained on how to use it in the field. **From the start of the Good Samaritan/ Naloxone Access law in 2013 through the end of 2017, Orange County has seen (a reported) 34 Community reversals, and 11 law enforcement reversals.** However, there is still much work to do. Orange County **saw more than 400 ED visits related to Medication/Drug poisoning in 2017.** More than a quarter of these were related to either opioids, heroin, or benzodiazepines (25.4%)

Opioid Overdose Reversals with Naloxone

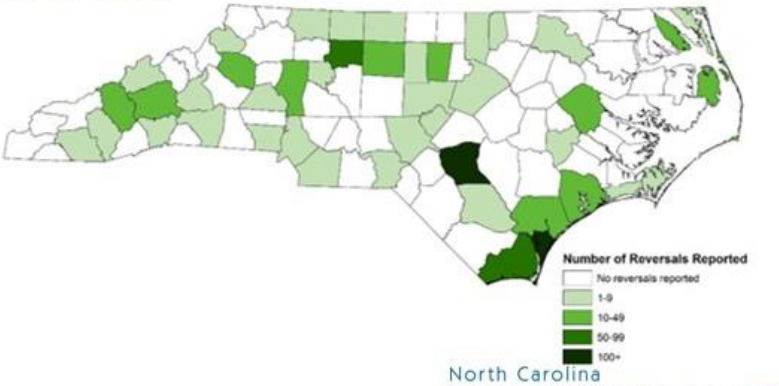
Community naloxone reversals reported to the NC Harm Reduction Coalition:
8/1/2013 - 12/31/2017 (9,632 total reversals reported)

Community Reversals in Orange County, as of 12/31/2017	34
Community Reversals in Local Health Director Region 5, as of 12/31/2017	2188



Law Enforcement naloxone reversals reported to the NC Harm Reduction Coalition:
1/1/2015 - 12/31/2017 (821 total reversals reported)

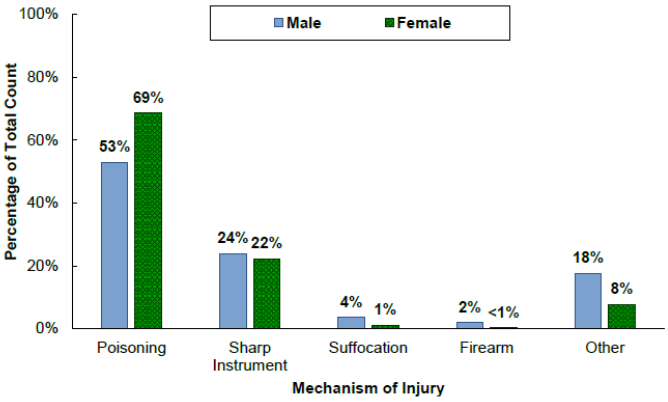
Law Enforcement Reversals in Orange County, as of 12/31/2017	11
Law Enforcement Agencies in Orange County carrying naloxone, as of 12/31/2017	4
Law Enforcement Reversals in Local Health Director Region 5 as of 12/31/2017	55
Law Enforcement Agencies in Local Health Director Region 5 carrying naloxone, as of 12/31/2017	22



Source: North Carolina Harm Reduction Coalition, January 2018
Analysis: Injury Epidemiology and Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch

Mechanism of Self-Inflicted Injury-Related NC ED Visits Stratified by Sex, 2012-2015



[1]"Other" includes the following mechanisms: motor vehicle collision, fire/burns, fall, drowning, late effects, unspecified, and all other specified, classifiable as well as specified, unclassifiable mechanisms of injury.

Orange County Overdose Related ED Visits, 2017

402	Medication/Drug visits
49	Opioid overdose visits
32	Heroin overdose visits
21	Benzodiazepine visits

Poisonings are the most common mechanism of self-inflicted injury-related ED visits in NC (62%).

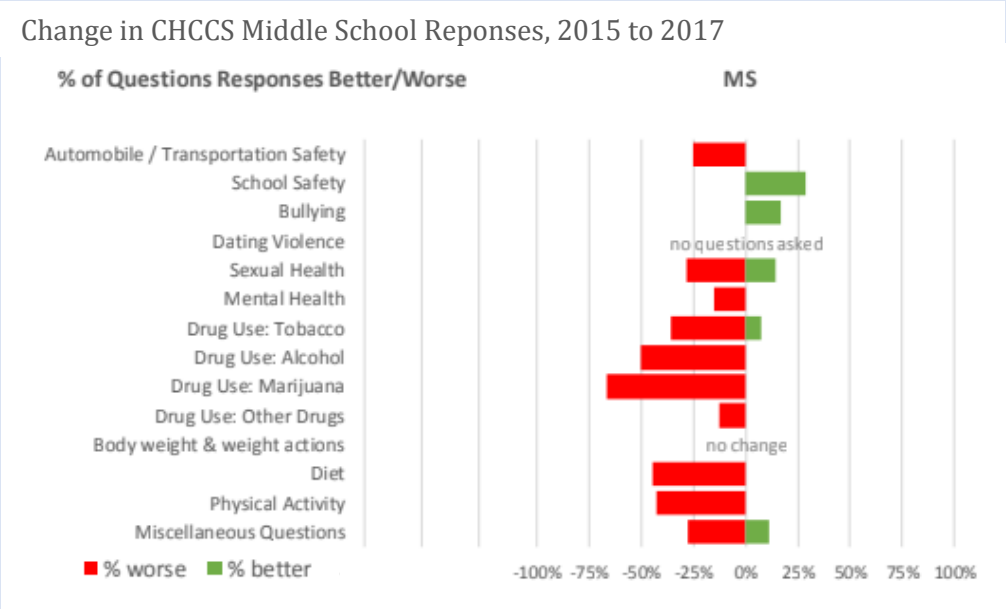
- A greater proportion of women visited the NC ED due to self-inflicted poisonings (69%) than men (53%).
- In Orange County, approximately 56% of medication/drug poisoning visits were female, and 45% were male.

Sources: *NC DETECT Report on Violent Injuries Treated in North Carolina Emergency Departments, 2012-2015 (2017), and NC DETECT ED Overdose Surveillance Report, Orange County (2017)*

Youth Substance Use and Mental Health

Youth Risk Behavior Survey Results, 2016-2017

Results from the 2017 Chapel Hill Carrboro City Schools (CHCCS) and 2016 Orange County Schools (OCS) Youth Risk Behavior Surveillance survey (YRBS) show a generation of youth with many health needs. Middle school students in particular appear to be at risk for many mental health conditions.



To the left is a visual for middle school question categories examined as a part of the 2017 YRBS in CHCCS, and the percent of questions that showed better/ worse response trends.

Only 8% of middle school questions (7/73) showed movement in a positive direction, while 37% (31/73) show movement in a negative direction.

Source and Data Notes: *YRBS data analysis and the graphics shown here were completed by Mike Dolan Fliss, Epidemiology PhD student at Gilling's School of Global Public Health. A complete report of findings can be found at the following website:*
http://www.chccs.k12.nc.us/parents/health-services-programs/youth-risk-behavior-surveys

YRBS data show students face stressors in their day to day lives (CHCCS).

1 in 5 middle and high school students is eligible for Free or Reduced Lunch

> 3 in 10 middle and high school students report their family feels financial stress.

70% high school students report getting fewer than 8 hours of sleep a night

YRBS data show students are dealing with mental health conditions (CHCCS).

1 in 5 high school students and **1 in 10** middle school students has been prescribed medication for mental health; similarly

1 in 5 high school students, and **1 in 10** middle school students report they would use mental health services provided at school if they were free and confidential.

YRBS data show students are at risk for physical self-harm (CHCCS and OCS).

1 in 10 middle school students has made a suicide plan,

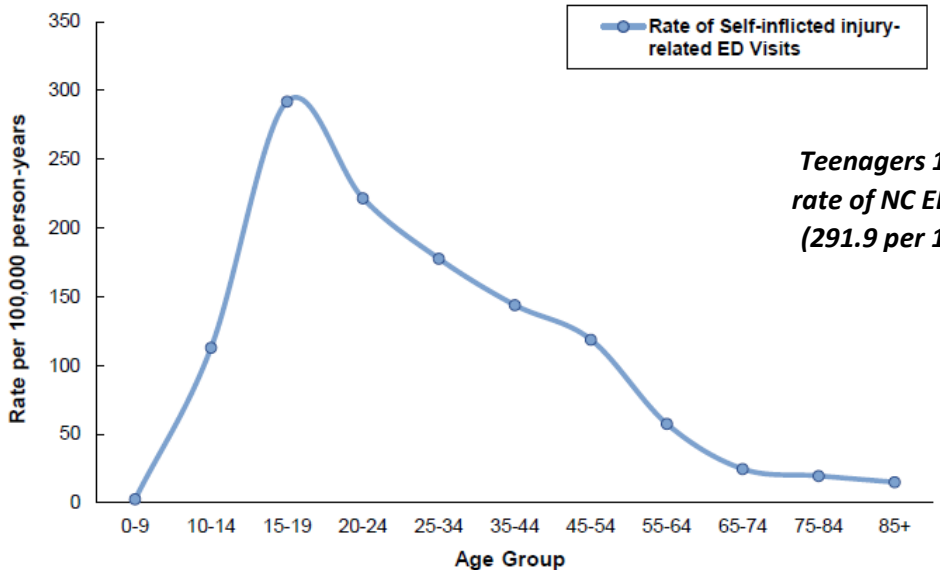
13% middle school students reported purposely hurting themselves.

1 in 25 middle school students has attempted suicide.

Mental Health and Self Harm in NC

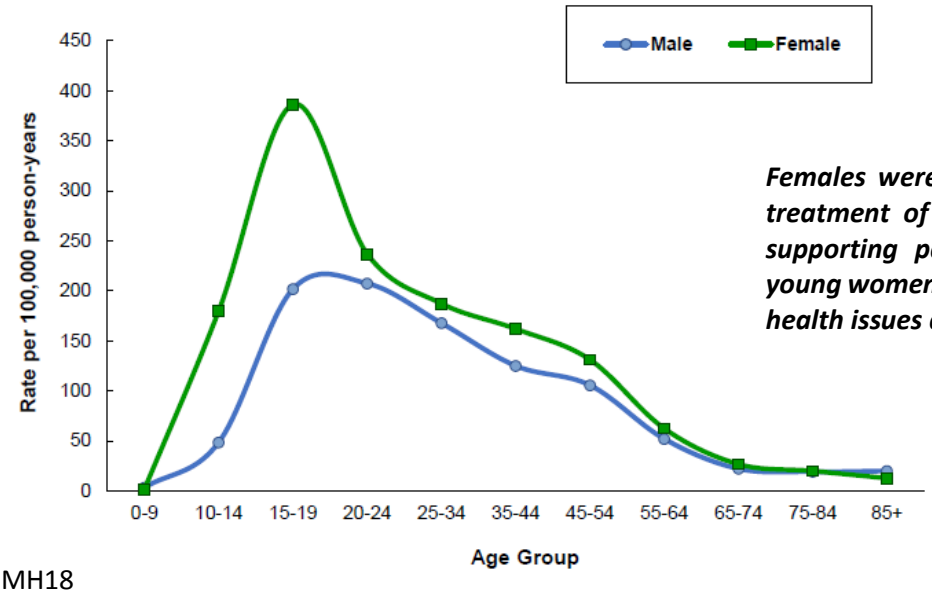
Summary:
There were more than 40,000 NC ED Visits due to self-inflicted injuries during the period January 1, 2012 – September 30, 2015 (111.8 per 100,000 person-years). **Females were more likely to visit a NC ED for treatment of self-inflicted injuries than males** (126.8 versus 96.0 ED visits per 100,000 person-years, respectively). **Teenagers 15-19 years of age had the highest rate of NC ED visits due to self-inflicted injuries** (291.9 per 100,000 person-years), followed by individuals aged: 20-24 (221.5), 25-34 (177.6), 35-44 (143.8) and 45-54 years of age (118.7). **These data support patterns seen in YRBS data in Orange County that show youth, and particularly young women are at an increased risk for mental health issues and self-harm.**

Unadjusted Rates of Self-Inflicted Injury-Related NC ED Visits, 2012-2015



Teenagers 15-19 years of age had the highest rate of NC ED visits due to self-inflicted injuries (291.9 per 100,000 person-years), 2015-2017.

Unadjusted Rates of Self-Inflicted Injury-Related NC ED Visits, Stratified by Sex and Age Group, 2012-2015



Females were more likely to visit a NC ED for treatment of self-inflicted injuries than males, supporting patterns seen in YRBS that show young women are at an increased risk for mental health issues and self-harm.

Source: *NC DETECT Report on Violent Injuries Treated in North Carolina Emergency Departments, 2012-2015 (2017)*

Chronic Disease and Obesity

5 of 10 measures in caution or alert zone

Summary: Overall, Orange County performs well compared to peers and NC when it comes to chronic disease and obesity. The exception that continually appears is in Female breast cancer, where Orange County often shows higher rates of both incidence and mortality. **However for the first time in many years, Orange County saw a decrease in breast cancer mortality**. However, prostate cancer and diabetes mortality saw a slight increase in 2016. ***Rates** are per 100,000 unless otherwise noted*

- Performing better than four or more benchmarks
- Performing better than two or three benchmarks
- Performing better than one or no benchmarks

Benchmarks include Previous, Peer, NC, US, and 2020 Target
OC Targets represent proposed local goals

- ↑↓ Positive trend
- ↑↓ Negative trend
- SAME No trend
- \- Trend cannot be assessed

Significant change from previous that is positive, negative, or indeterminable (grey)

Cancer	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Cancer Incidence Rate	▲	447	*445*	451	SAME	449	465	439	NA
Cancer Mortality Rate	●	146	*145*	152	SAME	156	167	159	161
Female Breast Cancer Incidence Rate	◆	177	*175*	180	SAME	138	158	126	NA
Female Breast Cancer Mortality Rate	●	16	*15*	20	↓	19	21	20	21
Lung Cancer Incidence Rate	●	54	*54*	55	SAME	62	66	55	NA
Lung Cancer Mortality Rate	●	41	*40*	42	SAME	43	48	41	46
Colorectal Cancer Incidence Rate	▲	32	*30*	33	SAME	30	36	39	NA
Colorectal Cancer Mortality Rate	▲	10	*9*	10	SAME	9	14	14	10
Prostate Cancer Incidence Rate	●	84	*84*	96	↓	88	109	113	NA
Prostate Cancer Mortality Rate	▲	19	*15*	17	↑	16	20	19	22

Diseases of the Heart	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Diseases of the Heart Mortality Rate	●	118	*103*	117	SAME	141	161	195	103

Stroke	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Stroke Mortality Rate	●	31	*30*	33	SAME	40	43	44	35

Diabetes	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Diabetes Diagnosis, Age Adjusted (20+)	▲	8%	*7%*	7%	-	8%	10%	9%	9%
Diabetes Mortality Rate	▲	17	*15*	15	↑	19	23	25	NA

Respiratory Diseases	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Asthma Current Diagnosis*	-	NA	*NA*	9%	-	NA	8%	9%	NA
% Asthma Diagnosis (ever in lifetime)*	-	NA	*NA*	18%	-	NA	13%	14%	NA
Lung Cancer Incidence Rate	●	54	*NA*	55	SAME	62	66	55	NA
Lung Cancer Mortality Rate	●	41	*40*	42	SAME	43	48	41	46

Obesity	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Adults Physical Inactive	▲	19%	*10%*	NA	-	18%	25%	26%	10%
% Adults who are Obese	▲	23%	*20%*	NA	-	22%	30%	32%	20%

Clinical Preventative Services	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Colorectal Cancer Screening*	-	NA	*71%*	61%	-	NA	73%	67%	71%
% Women who received Mamogram (50+)*	-	NA	*81%*	81%	-	NA	79%	68%	81%

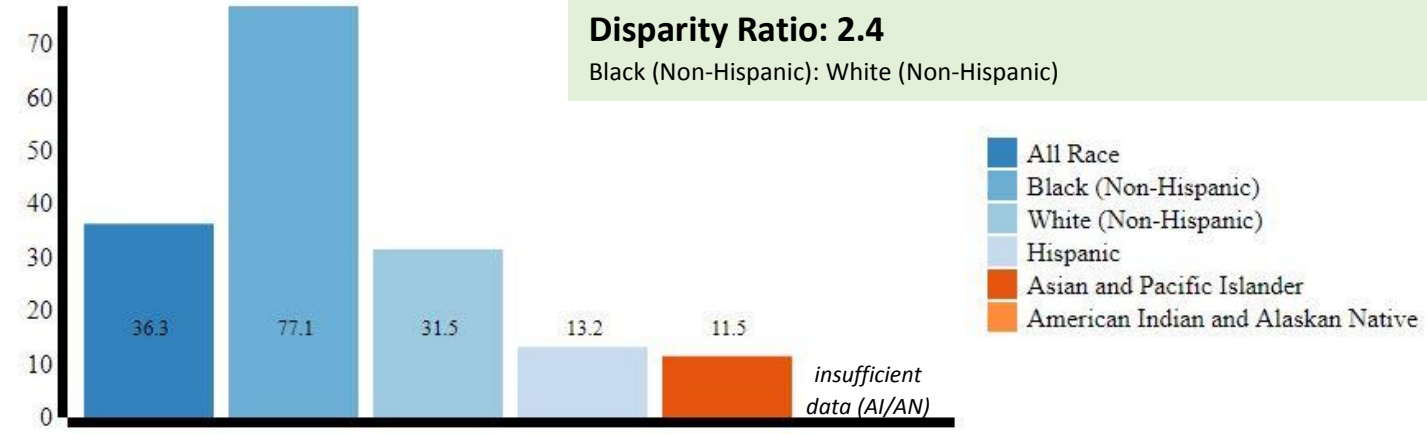
***Sources:** NC SCHS (2015-16), BRFSS (2011), SEER (2015-16). **Rates** are per 100,000 unless otherwise noted*

Chronic Disease Disparities

Summary: While Orange County performs well compared to peers and NC when it comes to chronic disease, the county has vast health disparities, particularly regarding chronic diseases. **Black (Non-Hispanic) residents in Orange County die from avoidable chronic diseases such as Heart Disease and Stroke at more than two times the rate of their White (Non-Hispanic) peers (77.1 vs 31.5 deaths per 100,000)**. They are also more likely than white residents to be hospitalized for chronic conditions such as cardiovascular disease (64.9 per 100,000 vs 44.8 per 100,000, respectively).

Orange, NC

Avoidable Heart Disease and Stroke Death Rate per 100,000, All Race, All Gender, 2013-2015



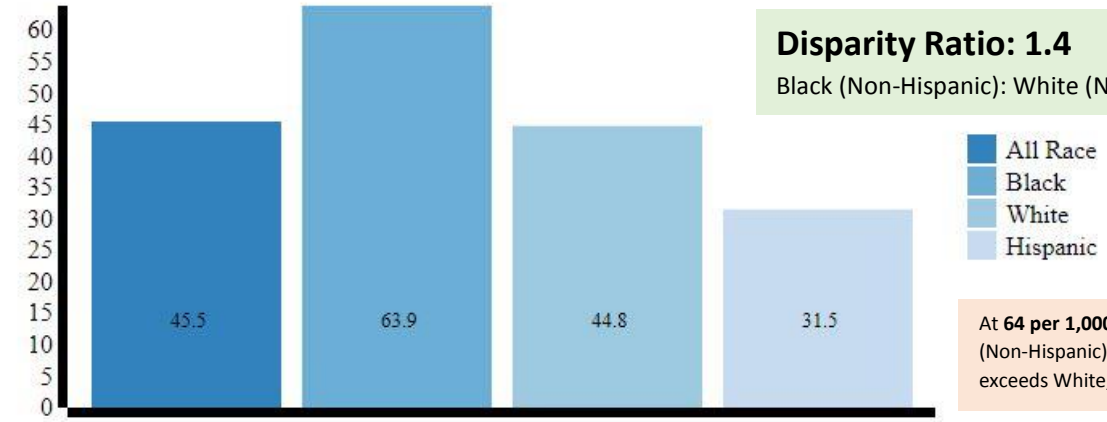
Disparity Ratio: 2.4
Black (Non-Hispanic): White (Non-Hispanic)

Regional Rates	Rate*
National Rate	58.2
State Rate	61.9

At **77 deaths per 100,000 people**, Black (Non-Hispanic) rates of avoidable Heart Disease and Stroke Deaths exceed both the National and State Rates.

Orange, NC

Total Cardiovascular Disease Hospitalization Rate per 1,000 Medicare Beneficiaries, 65+, All Race, All Gender, 2012-2014



Disparity Ratio: 1.4
Black (Non-Hispanic): White (Non-Hispanic)

At **64 per 1,000 Medicare Beneficiaries**, the Black (Non-Hispanic) rate of CVD Hospitalizations exceeds White, Hispanic, and the County average.

Source: CDC/DHDSP Atlas of Heart Disease and Stroke (2012-2015)

Social Determinants of Health

8 of 10 measures in caution or alert zone

24%	52%	24%

Summary:
Orange County consistently falls short of the nation, state, and/or peers when it comes to Social Determinants of Health. In particular, **affordable housing, food insecurity, and income inequality are key and pressing issues for our County. 14% of children in Orange County live in poverty, and 36% of students are eligible for free or reduced lunch.** In addition, 1 in 5 residents are experiencing serious housing problems such as overcrowding or a need for repairs. **Half of Orange County renters pay unaffordable rates for housing** at 30% or more of their income. And of those facing food insecurity, 40% are ineligible for SNAP benefits. These stressors affect students, as evidenced by a drop in the graduation rate for economically disadvantaged students in 2017 (76% from

Source: *Feeding America (2015)*

- Performing better than four or more benchmarks
- Performing better than two or three benchmarks
- Performing better than one or no benchmarks

Benchmarks include Previous, Peer, NC, US, and 2020 Target
OC Targets represent proposed local goals

↑↓ Positive trend
↑↓ Negative trend
SAME No trend
\- Trend cannot be assessed

Significant change from previous that is positive, negative, or indeterminable (grey)

Poverty	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Population living in Poverty	△	15%	*10%*	15%	SAME	15%	17%	16%	13%
% Children <18 living in Poverty	△	14%	*10%*	12%	↑	22%	25%	22%	NA
% Households on SNAP benefits	-	8%	*NA*	7%	SAME	12%	15%	13%	NA
% Children Eligible for Free or Reduced Lunch	△	36%	*NA*	35%	SAME	55%	60%	50%	NA
% Children Eligible for Free or Reduced Lunch (OCS)	△	47%	*NA*	44%	↑	55%	60%	50%	NA
% Children Eligible for Free or Reduced Lunch (CHCCS)	△	29%	*NA*	30%	SAME	55%	60%	50%	NA

Sources: *ACS (2015-16), NC Public Schools (2015-16, 2016-17), NCES (2011-13)*

Social Determinants of Health	Progress	Orange County		Trend		Compare to			
`	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Population that is Food Insecure	△	13%	*6%*	15%	SAME	13%	15%	13%	6%
% Unemployed	●	4%	*3%*	6%	↓	4%	6%	5%	NA
% Renters paying >30% Income on Rent	△	50%	*36%*	46%	↑	52%	49%	51%	36%
% Households living with severe housing problems	◆	19%	*14%*	NA	-	16%	16%	14%	NA
Gini Coefficient of Income Inequality (0= most equal, 1.0 = least equal)	◆	0.52	*NA*	0.53	-	0.45	0.47	0.48	NA

Sources: *ACS (2015-16), CDC DHDSP Atlas (2013)*

Disparities in Educational Achievement	Progress	Orange County		Trend		Compare to			
	Icon	Current	Target	Previous	Progress	Peer	NC	US	2020 Target
4 year Graduation Rate (%)	●	89%	*95%*	89%	SAME	88%	87%	83%	*95%*
4 year Graduation Rate (EDS) (%)	◆	76%	*95%*	80%	↓	85%	82%	78%	95%
4 year Graduation Rate (Hispanic) (%)	△	83%	*95%*	82%	SAME	88%	81%	79%	*95%*
4 year Graduation Rate (Black) (%)	△	85%	*95%*	86%	SAME	89%	84%	76%	95%
4 year Graduation Rate (White) (%)	●	92%	*95%*	92%	SAME	88%	89%	88%	*95%*

Sources: *NC Public Schools (2015-16, 2016-17), NCES (2011-13)*

Social Determinants of Health: Access to Care

Summary:

North Carolina and Orange County each saw a decline in the percent of residents who are uninsured from 2014 to 2016 (age <65 years old). Orange County low-income uninsured also continues to drop, from 32% in 2014, to now 23%. Orange County has seen a steady decline in uninsured rates across all indicators from 2011 to 2014. **However, the percentage of low income children who were uninsured (12%) is still much higher than in our peer counties, the state, and the nation.** Orange County and NC lag behind the US in nearly all insurance indicators, likely in part due to the exclusion of a Medicaid expansion for low-income individuals and a changing insurance environment.

In terms of resources, Orange County leads the state in physician density, and the supply of physicians grew from 2013 to 2016. In 2013 and 2014, Orange County ranked first in dentist density. Although there was a large decrease in the number of dentists in 2013, this trend reversed in 2014, with the dentist rate increasing by more than 6 dentists per 10,000 people. Trends in 2016 continue to show growth in both physician and dentist density.

- Performing better than four or more benchmarks
- Performing better than two or three benchmarks
- Performing better than one or no benchmarks

Benchmarks include Previous, Peer, NC, US, and 2020 Target
OC Targets represent proposed local goals

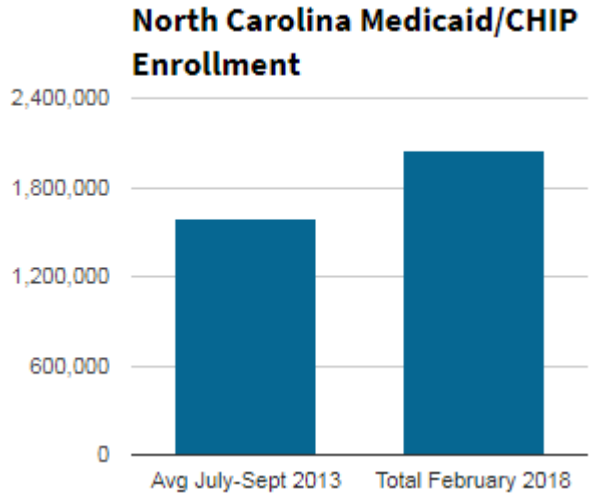
- ↑↓ Positive trend
- ↑↓ Negative trend
- SAME No trend
- \- Trend cannot be assessed

Significant change from previous that is positive, negative, or indeterminable (grey)

Affordability and Insurance	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% Uninsured (<65 years old)	●	10%	*8%*	12%	SAME	20%	12%	9%	8%
% Low-income Uninsured (<65 years old, <200% FPL)	◆	23%	*20%*	26%	↓	20%	21%	16%	NA
% Children Uninsured (<19 years old)	△	5%	*4%*	6%	SAME	4%	5%	5%	NA
% Low Income Children Uninsured (<19 years old, <200% FPL)	◆	12%	*5%*	12%	SAME	6%	6%	7%	NA

Resources and Prevention	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Physicians Rate per 10,000	●	120	*NA*	111	↑	43	23	26	NA
Dentist Rate per 10,000	●	18	*NA*	16	↑	8	5	6	NA

Sources: *SAHIE (2014-2016), Sheps Center (2014-2015), Kaiser Family Foundation (US Measures, 2015-2016), Medicaid.gov (2018)*
Data Notes: *See the* ***Public Health Dashboard FAQ Document*** *for more on data methodology.*



As of February 2018, North Carolina has enrolled 2,055,472 individuals in Medicaid and CHIP — a net increase of 29% since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013. However, NC falls five percentage points (5%) behind the US, and Orange County falls seven percentage points (7%) behind.

In numbers, this represents a difference of nearly 187,000 low-income individuals in NC and **more than 10,000 low-income individuals in Orange County that would be covered if the county's uninsured rates matched those of the United States.**

2018 Population Health Dashboards
Orange County, NC

8 of 10 measures in caution or alert zone

20%	40%	40%

Sexually Transmitted Infections

Summary:

The incidence of most STIs increased in 2016 for Orange County, as it has done for the past several years. Gonorrhea, Chlamydia and HIV Infection Rates in particular are higher for Orange County than our peers, and increasing at a significant rate. **From 2012-2016, Chlamydia increased at a faster rate in Orange County than in North Carolina** (~13 case increase a year per 100,000 for NC vs ~35 case increase a year per 100,000 for Orange County. Disaggregated data from 2015 by township has shown that these higher rates of STIs are affecting both urban and rural areas of the county.

- Performing better than four or more benchmarks
- Performing better than two or three benchmarks
- Performing better than one or no benchmarks

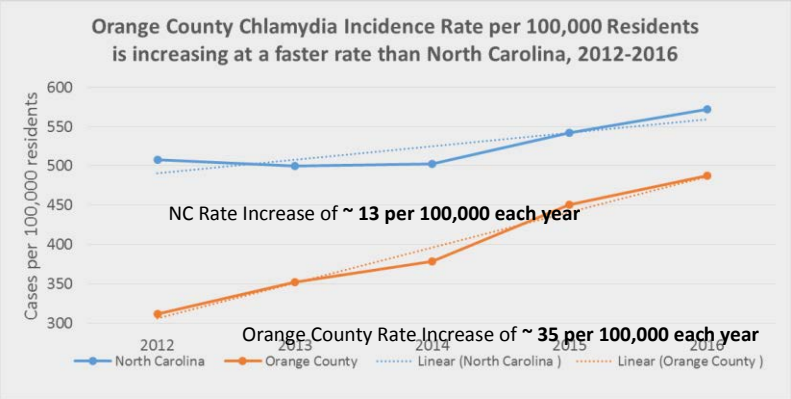
Benchmarks include Previous, Peer, NC, US, and 2020 Target
OC Targets represent proposed local goals

- ↑↓ Positive trend
- ↑↓ Negative trend
- SAME No trend
- \- Trend cannot be assessed

- Significant change from previous that is positive, negative, or indeterminable (grey)

Sexually Transmitted Infections (STIs)	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
% age 15-24 testing positive for Chlamydia of those tested	-	NA	9%	9%	-	NA	NA	NA	9%
Chlamydia Incidence Rate (/100,000)	◆	488	NA	377	↑	275	572	497	NA
Early Syphilis Rate (/100,000)	●	9	NA	11	↓	4	16	18	NA
Gonorrhea Incidence Rate (/100,000)	◆	123	NA	88	↑	107	194	146	NA

HIV/AIDS	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
AIDS Incidence Rate (/100,000)	▲	6	12	6	SAME	3	8	6	12
HIV Infection Rate (/100,000)	▲	9	22	8	↑	11	16	12	22



Sources: *NC DHHS HIV/STD Surveillance Report (2015-16). Data points are the most current measures from multiple sources (available on request) .*

Data Notes: *See the* ***Public Health Dashboard FAQ Document*** *for more on data methodology.*

Chlamydia, 2015

Township	Cases	Rate(per 100,000)
Orange County	473	335
Bingham	17	254
Cedar Grove	25	506
Chapel Hill	320	350
Cheeks	30	306
Eno	17	217
Hillsborough	58	403
Little River	6	167

Red Townships are showing rates above the County Rate of 335 cases/ 100,000 cases

Gonorrhea, 2015

Township	Cases	Rate(per 100,000)
Orange County	130	92
Bingham	8	119
Cedar Grove	*	*
Chapel Hill	68	74
Cheeks	8	82
Eno	7	90
Hillsborough	30	209
Little River	5	139

Red Townships are showing rates above the County Rate of 92 cases/ 100,000 cases

* Townships with fewer than 5 cases are suppressed

2018 Population Health Dashboards
Orange County, NC

Injury and Violence

7 of 10 measures in caution or alert zone

Summary:

Alcohol related vehicle indicators showed improvement from 2015 to 2016, which was identified as an area of concern on previous dashboards. Both alcohol related crash rates and reported drinking and driving behaviors among youth saw a decrease. **However, texting and driving is rising among youth (21% in 2017, compared to 17% in 2015).** 2016 also saw an increase in several indicators related to violent crime**. In particular, the indicator for rape crimes increased from 15 per 100,000 to 21 per 100,000.** While sexual assault crimes are often under reported, national media trends have increasingly reported on a movement to hold public figures responsible for these crimes and may account for some of this increase in reporting at the local level. In any case, this is an indicator to be aware of for Orange County as it is on the rise and greater than or peers. **Drug overdose is an additional area of concern, examined in greater depth as a part of the *2018 Substance Use and Mental Health Dashboard***.

- Performing better than four or more benchmarks
- Performing better than two or three benchmarks
- Performing better than one or no benchmarks

Benchmarks include Previous, Peer, NC, US, and 2020 Target
OC Targets represent proposed local goals

- ↑↓ Positive trend
- ↑↓ Negative trend
- SAME No trend
- \- Trend cannot be assessed

Significant change from previous that is positive, negative, or indeterminable (grey)

Motor Vehicle Safety and Accidents	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Crash Injuries Per 1000 People	△	8	*7*	8	SAME	9	13	NA	7
Unintentional Motor Vehicle Mortality Rate	●	8	*8*	8	SAME	11	14	12	NA
% Crashes that are Alcohol Related	△	4%	*5%*	5%	↓	4%	4%	5%	5%
% Adults who drove after drinking in past 30 days*	-	NA	*NA*	8%	-	4%	3%	2%	NA
% High schoolers who rode with someone who had been drinking (CHCCS)**	△	12%	*NA*	16%	↓	NA	17%	20%	NA
% High schoolers who rode with someone who had been drinking (OCS)***	-	13%	*NA*	NA	-	NA	17%	20%	NA
% High schoolers who texted while driving in past 30 days(CHCCS)**	△	21%	*NA*	17%	↑	NA	38%	41%	NA
% High schoolers who texted while driving in past 30 days(OCS)***	△	31%	*NA*	17%	↑	NA	38%	41%	NA

Violence and Crime	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Violent Crime Rate per 100,000	△	173	*NA*	148	↑	148	375	386	NA
Assault Rate per 100,000	△	104	*88*	88	↑	182	251	250	192
Rape Rate per 100,000	△	21	*NA*	15	↑	13	21	37	NA
Homicide Rate per 100,000	●	4	*6*	4	SAME	6	7	5	6
% High schoolers who had been injured in a fight (CHCCS)**	●	1%	*NA*	3%	↓	NA	3%	3%	NA
% High schoolers who experienced dating violence (CHCCS)**	-	2%	*NA*	2%	SAME	NA	8%	10%	NA
% High schoolers who experienced forced intercourse (CHCCS)**	△	4%	*NA*	3%	↑	NA	7%	7%	NA

Opioids and Drug Overdose	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Drug Overdose Mortality Rate	△	13	*10*	7	↑	32	19	20	NA
Opioid Overdose Mortality Rate	△	6	*5*	4	↑	16	15	13	NA

Unintentional Injuries	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Other Unintentional Mortality Rate (Age-Adj)	●	25	24	26	SAME	35	32	43	36

Data Notes:
**Due to changes in survey methodology and overlapping confidence intervals, BRFSS data cannot be compared to previous years*
***Confidence intervals for YRBS trend data are unavailable to assess significance of trends over time.*
****Sample size for OCS YRBS was small due to an active consent process and may not represent general population rates*
*Rates are per 100,000 unless otherwise noted. See the **Public Health Dashboard FAQ Document** for more on data methodology.*

Sources: *YRBS (2015, 2017), NC DPS (2015,2016), NCSBI (2015, 2016), NC SCHS (2015, 2016)*
Data points are the most current measures from multiple sources (available on request).

2018 Population Health Dashboards
Orange County, NC

Maternal and Infant Health

3 of 10 measures in caution or alert zone

Summary:

Orange County performs well on most indicators of Maternal and Infant Health. **However, 2016 saw an increase in the teen pregnancy rate and % of teen pregnancies that are repeat. 1 in 4 teen pregnancies in 2016 were repeat teen pregnancies.** *With small numbers, it is important to remember that fluctuations in indicators such as these is expected from year to year.* **Many disparities exist for these indicators by race and ethnicity. Non-Hispanic Black Babies in particular are at high risk for either a low or very low birth weight as compared to other race and ethnicity groups.** Approximately 13% Non-Hispanic black children are born low birth weight as compared to 6% Non-Hispanic White children. Similarly 3.2% Black children have a very low birth weight, whereas only 1.2% Non-Hispanic White births are very low birth weight.

- Performing better than four or more benchmarks
- Performing better than two or three benchmarks
- Performing better than one or no benchmarks

Benchmarks include Previous, Peer, NC, US, and 2020 Target
OC Targets represent proposed local goals

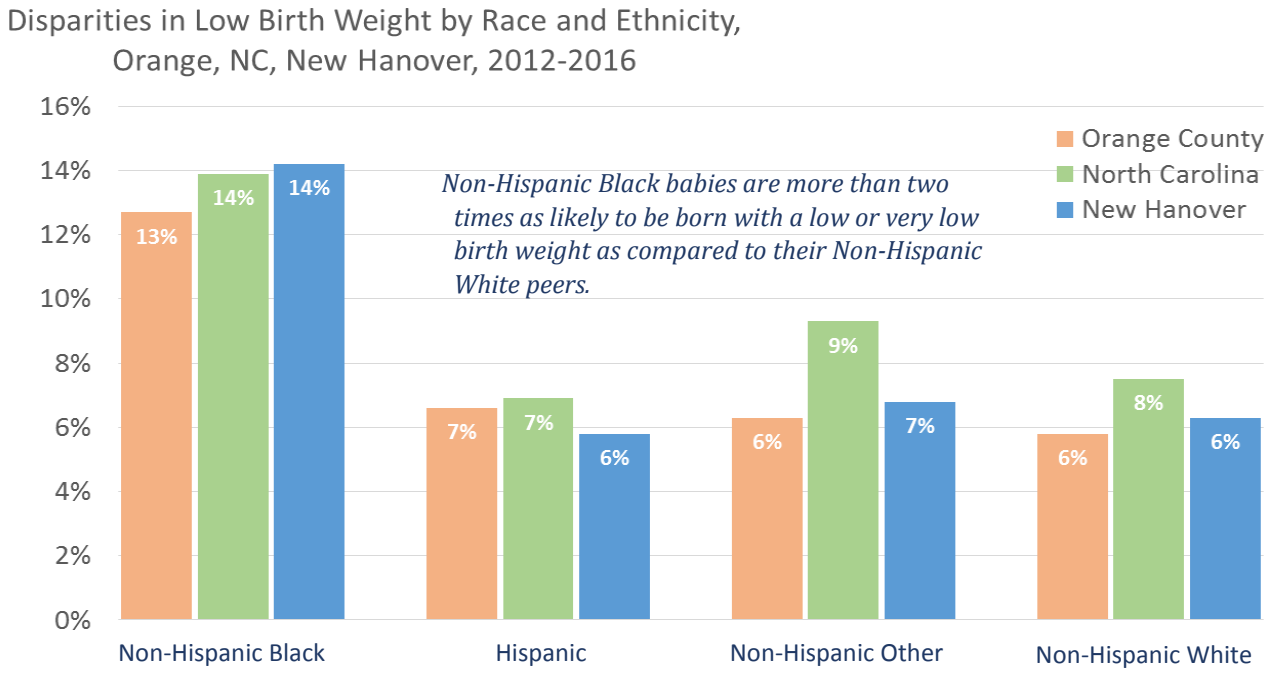
- ↑↓ Positive trend
- ↑↓ Negative trend
- SAME No trend
- \- Trend cannot be assessed

Significant change from previous that is positive, negative, or indeterminable (grey)

Birth Outcomes	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Infant Mortality Rate (/1,000)	●	5	*6*	5	↓	6	7	6	6
Infant Mortality Rate Disparity (AA:White)	◆	2.5	*NA*	3.2	↓	1.7	2.4	2.4	NA
% Low Birthweight Babies (<2500 grams)*	●	6.9%	*7.4%*	6.8%	SAME	7.7%	9.0%	8.7%	7.4%
% Very Low Birthweight Babies (<1500 grams)*	●	1.1%	*1.4%*	1.2%	SAME	1.3%	1.7%	1.4%	1.4%
% Mothers Smoking while pregnant	▲	5%	*1%*	6%	SAME	4%	10%	7%	1%
% Preterm Births (<37 Wks Gestation)*	●	8%	*11%*	8%	SAME	9%	10%	10%	11%

Teen Pregnancy	Progress	Orange County		Trend		Compare to			
	Icon	Current	Proposed OC Target	Previous	Progress	Peer	NC	US	2020 Target
Teen Pregnancy (Rate/1,000)	●	8	*NA*	6	↑	20	30	22	NA
Repeat Teen Pregnancy Rate	●	25%	*NA*	17%	↑	20%	22%	18%	NA

Sources: *NC SCHS (2015-16), CDC (2015-16). Data points are the most current measures from multiple sources (available on request).*
Data Notes: *See the* ***Public Health Dashboard FAQ Document*** *for more on data methodology.*



Source: *NC SCHS (2012-2016)*

2018 Public Health Dashboards

Orange County Health Department
Hillsborough, NC

About the Orange County Public Health Dashboards

Orange County's Public Health Dashboards were first developed in 2014 and provide an executive level view of how the county is performing on indicators in major public health content areas as compared to the state, nation, peers, and available targets or goals. The Orange County Health Department uses these data for community presentations, to identify areas of interest for further investigation, to identify opportunities for collaboration with partners, and in prioritizing funding and program planning through the Healthy Carolinians Community Health Assessment process. Local Community Based Organizations may also use these data for grant proposals, strategic planning, and evaluation of programs or policies.

Icons provide quick reference to indicators of note, and how Orange County compares to these benchmarks. It is important to note that these icons serve as a starting point for conversations, but there are many stories to tell behind each indicator. For example, an indicator with a green circle may not alert the reader to health disparities for a specific demographic group within an indicator data set. The absence of disparity measures is a general limitation of this indicator set that the department continues to build out as it improves with each dashboard iteration.

The data included in these dashboards are the most up to date data available for Orange County. In some cases, there may be more recent data available for peers, the state, or the US; however, benchmark values are selected from the same year as the Orange County data where possible, for consistency of comparison. A dwindling number of local level indicators (previously supplied by the Behavioral Risk Factors Surveillance Survey (BRFSS), highlights the need for intentional survey development and implementation as a part of the Community Health Assessment Survey in 2019.

The over-arching content areas selected for our dashboards are based on current county priority areas and on the topic area categories included in the Healthy People 2020 and Healthy North Carolina 2020 Objectives. In order to present a meaningful set of data that develops an executive level picture for what is happening in our county's health, we only include indicators that meet several criteria. These criteria help contextualize county measures by relating them to comparable benchmarks. Meaning, a number by itself does not give you any frame of reference unless you have other measures to compare it with. In some cases, an indicator may meet several but not all of these criteria. In general, an indicator must meet a majority of these criteria to be included in the dashboard. We aim to select measures that are meaningful to public health and which meet the following requirements:

1) annual measures
2) updated on a regular basis
3) available at the county level
4) have existing objectives, targets, or benchmarks (such as the HP2020 or HNC2020 Objectives)
5) are commonly used measures across geographies (other counties, the state, the US)

Review of Major Findings from 2017 Public Health Dashboards

In 2017, 9 dashboards were completed, some of which have now been consolidated by priority content areas for this year's dashboards. Drug and opioid overdose mortality rates in Orange County were increasing. More than a quarter (26%) of Orange County opioid deaths from 2009-2013 came from the town of Hillsborough, which makes up only 5% of Orange County's population. In Orange County, more than 1 in 3 high school students had tried e-vapor products (37%), which was a new question added to the YRBS in Chapel Hill Carrboro City Schools. Nearly 1 in 5 students was a current user of e-vapor products (18%). Orange County performed well on most chronic disease indicators. However, prevalence of chronic diseases has increased in the last decade. The death rate due to diabetes increased from 11.4 deaths per 100,000 people in 2013 to nearly 15 deaths per 100,000 people in 2015 (which has risen again in 2016). Breast cancer mortality had been declining; however, breast cancer incidence was steadily rising from around 160 new cases per 100,000 in 2014, to 180 new cases per 100,000 in 2015. Orange County had the highest Gini Coefficient of Income Inequality of those counties in NC with a population larger than 60,000 people (0.53). In Orange County, the percentage of low income children who are uninsured (12%) was higher than in our peer counties, the state, and the nation. Incidence of most STIs had increased, with significant increases in gonorrhea and HIV infection rates in Orange County compared to our peers. African American infants were more than three times as likely to die as non-Hispanic white babies in Orange County (disparity ratio of 3.2).

2018 Public Health Dashboards: Executive Summary

The following pages include a summary of the key take-away findings from this year's public health dashboards. There are 6 completed dashboards, available as separate documents. For additional FAQs on dashboard development, please also reference our Dashboard Companion Document.

Substance Abuse and Mental Health

Orange County saw significant increases in both Drug Overdose and Opioid Overdose mortality rates in 2016. However, it is important to remember that as a county with a small population, sizable fluctuation in rates from year to year is not unusual. It appears on several measures (alcohol, marijuana, and smoking cigarettes or e-cigarettes), High School substance use decreased from 2015 to 2017 (CHCCS). Additionally, fewer students reported that they believed vaping is low in harm. However, more Orange County students report current marijuana use than NC or the US. Depression continues to be a common condition that close to 1 in 5 residents face, young and old.

Opioid Use and Overdose

The drug overdose mortality rate in Orange County has increased from 5.7 deaths per 100,000 residents in 2014 to 12.6 deaths per 100,000 residents in 2016. The rate of opioid overdose mortality has also risen from 3.6 deaths per 100,000 in 2014 to 6.3 deaths per 100,000 in 2016. The number of providers registered in the NC Controlled Substance Reporting System has risen in the past 5 years and estimated percent of providers using the system is comparable to peer counties. However, opioid medications are not the only drugs showing an elevated appearance as a cause of death in the last several years. Other synthetic narcotics, cocaine, and heroin also saw increases as contributors to overdose mortality in 2016. Orange County saw more than 400 ED visits related to Medication/Drug poisoning in 2017. More than a quarter of these were related to either opioids, heroin, or benzodiazepines (25.4%).

Opioid and Other Drug Prescribing

Orange County is ranked #1 (best) in the state when it comes to the number of Opioid prescriptions (.52) or pills prescribed per resident (34.5) in 2016, which represents an average. This puts Orange County on par with the lowest quartile state averages in the US in 2014 (.52-.71). Regional neighbors are prescribing at similar rates, while we are doing slightly better than western peers (Buncombe), and much better than coastal ones (Brunswick). However, Orange County is ranked 75th on average strength of Opioid prescription (54.2) per resident. This measure uses algorithms to translate all prescriptions to a single measure of MME (morphine milligram equivalents). The risk for overdose is directly associated with the use of multiple prescribers and daily dosages of >100 morphine milligram equivalents (MMEs) per day (CDC).

For Benzodiazepines, Orange County is ranked 10th at .3 Rx/resident and 15.3 pills /resident. Unlike Opioid use, which increases with age, anxiety is most prevalent in people aged 30-44, so a larger population in this age group may affect this measure (although national Rx trends do not reflect along the age trends one would expect, actually seeing an increase in benzodiazepine Rx with age). Opioid and benzodiazepine prescribing rates have been stable over the past 6 years in Orange County. However, the stimulant prescribing rate has increased from 24 prescriptions per 100 residents to 30, placing Orange County 96th out of 100 counties.

Response to the Opioid Epidemic

In response to the Opioid epidemic, representatives of North Carolina and public health professionals from the injury and violence prevention branch and broader health community put together the North Carolina Opioid Action Plan. This plan, initiated in 2017, will run through 2021 and focuses on prevention, treatment, and recovery efforts to reduce mortality and morbidity related to drug use and overdose. As stated on the DHHS website, strategies of the plan include:

- Coordinating the state's infrastructure to tackle the opioid crisis.
- Reducing the oversupply of prescription opioids.
- Reducing the diversion of prescription drugs and the flow of illicit drugs.
- Increasing community awareness and prevention.
- Making naloxone widely available.
- Expanding treatment and recovery systems of care.
- Measuring the effectiveness of these strategies based on results.

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As part of an effort to reduce overdose deaths, all four Orange County branches of law enforcement carry naloxone, an overdose reversal drug, and have been trained on how to use it in the field. From the start of the Good Samaritan/ Naloxone Access law in 2013 through the end of 2017, Orange County has seen (a reported) 34 Community reversals, and 11 law enforcement reversals.

Youth Mental Health and Self Harm

Results from the 2017 Chapel Hill Carrboro City Schools and 2016 Orange County Schools Youth Risk Behavior Surveillance Survey show a generation of youth with many health needs. Middle school students in particular appear to be at risk for many mental health conditions. Only 8% of middle school questions from CHCCS showed movement in a positive direction, while 37% show movement in a negative direction as compared to 2017. YRBS data show students face stressors in their day to day lives, are dealing with mental health conditions, and are at risk for physical self-harm.

- **1 in 5** high school students and **1 in 10** middle school students has been prescribed medication for mental health; and similarly, **1 in 5** high school students, and **1 in 10** middle school students report they would use mental health services provided at school if they were free and confidential.
- **1 in 10** middle school students has made a suicide plan,
- **13%** middle school students reported purposely hurting themselves.
- **1 in 25** middle school students has attempted suicide.

There were more than 40,000 NC ED Visits due to self-inflicted injuries during the period January 1, 2012 – September 30, 2015 (111.8 per 100,000 person-years). Females were more likely to visit a NC ED for treatment of self-inflicted injuries than males (126.8 versus 96.0 ED visits per 100,000 person-years, respectively). Teenagers 15-19 years of age had the highest rate of NC ED visits due to self-inflicted injuries (291.9 per 100,000 person-years), followed by individuals aged: 20-24 (221.5), 25-34 (177.6), 35-44 (143.8) and 45-54 years of age (118.7). These data support patterns seen in YRBS data in Orange County that show youth, and particularly young women are at an increased risk for mental health issues and self-harm.

Chronic Disease and Obesity

Overall, Orange County performs well compared to peers and NC when it comes to chronic disease and obesity. The exception that continually appears is in Female breast cancer, where Orange County often shows higher rates of both incidence and mortality. However for the first time in many years, Orange County saw a decrease in breast cancer mortality. However, prostate cancer and diabetes mortality saw a slight increase in 2016.

While Orange County performs well compared to peers and NC when it comes to chronic disease, the county has vast health disparities, particularly regarding chronic diseases. Black (Non-Hispanic) residents in Orange County die from avoidable chronic diseases such as Heart Disease and Stroke at more than two times the rate of their White (Non-Hispanic) peers (77.1 vs 31.5 deaths per 100,000). They are also more likely than white residents to be hospitalized for chronic conditions such as cardiovascular disease (64.9 per 100,000 vs 44.8 per 100,000, respectively).

Social Determinants of Health and Access to Care

Orange County consistently falls short of the nation, state, and/or peers when it comes to Social Determinants of Health. In particular, affordable housing, food insecurity, and income inequality are key and pressing issues for our County. 14% of children in Orange County live in poverty, and 36% of students are eligible for free or reduced lunch. In addition, 1 in 5 residents are experiencing serious housing problems such as overcrowding or a need for repairs. Half of Orange County renters pay unaffordable rates for housing at 30% or more of their income. And of those facing food insecurity, 40% are ineligible for SNAP benefits. These stressors affect students, as evidenced by a drop in the graduation rate for economically disadvantaged students in 2017 (76% from 80%).

North Carolina and Orange County each saw a decline in the percent of residents who are uninsured from 2014 to 2016 (age <65 years old). Orange County low-income uninsured also continues to drop, from 32% in 2014, to now 23%. Orange County has seen a steady decline in uninsured rates across all indicators from 2011 to 2014. However, the percentage of low income children who were uninsured (12%) is still much higher than in our peer counties, the state, and the nation. Orange County and NC lag behind the US in nearly all insurance indicators, likely in part due to the exclusion of a Medicaid expansion for low-income individuals and a changing insurance environment.

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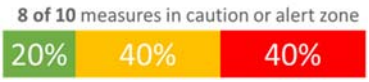
As of February 2018, North Carolina has enrolled 2,055,472 individuals in Medicaid and CHIP — a net increase of 29% since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013. However, NC falls five percentage points (5%) behind the US, and Orange County falls seven percentage points (7%) behind. In numbers, this represents a difference of nearly 187,000 low-income individuals in NC and more than 10,000 low-income individuals in Orange County that would be covered if the county's uninsured rates matched those of the United States.

In terms of resources, Orange County leads the state in physician density, and the supply of physicians grew from 2013 to 2016. In 2013 and 2014, Orange County ranked first in dentist density. Although there was a large decrease in the number of dentists in 2013, this trend reversed in 2014, with the dentist rate increasing by more than 6 dentists per 10,000 people. Trends in 2016 continue to show growth in both physician and dentist density.



Sexually Transmitted Infections (STIs)

The incidence of most STIs increased in 2016 for Orange County. Gonorrhea, Chlamydia and HIV Infection Rates in particular are higher for Orange County than our peers, and increasing at a significant rate. From 2012-2016, Chlamydia increased at a faster rate than North Carolina (~13 case increase a year per 100,000 for NC vs ~ 35 case increase a year per 100,000 for Orange County. Disaggregated data from 2015 by township has shown that these higher rates of STIs are affecting both urban and rural areas of the county.

Injury and Violence

Alcohol related vehicle indicators showed improvement from 2015 to 2016, which was identified as an area of concern on previous dashboards. Both alcohol related crash rates and reported drinking and driving behaviors among youth saw a decrease. However, texting and driving is rising among youth (21% in 2017, compared to 17% in 2015). 2016 also saw an increase in several indicators related to violent crime. In particular, the indicator for rape crimes increased from 15 per 100,000 to 21 per 100,000. While sexual assault crimes are often under reported, national media trends have increasingly reported on a movement to hold public figures responsible for these crimes and may account for some of this increase in reporting at the local level. In any case, this is an indicator to be aware of for Orange County as it is on the rise and greater than or peers. Drug overdose is an additional area of concern, examined in greater depth as a part of the Substance Use and Mental Health dashboard and summary.

Maternal and Infant Health

Orange County performs well on most indicators of Maternal and Infant Health, however many disparities exist for these indicators by race and ethnicity. In 2016, Orange County also saw an increase in the teen pregnancy rate and % of teen pregnancies that are repeat. 1 in 4 teen pregnancies in 2016 was a repeat teen pregnancy. With small numbers, it is important to remember that fluctuations in indicators such as these is expected from year to year. Non-Hispanic Black Babies in particular are at high risk for either a low or very low birth weight as compared to other race and ethnicity groups. Approximately 13% Non-Hispanic black children are born low birth weight as compared to 6% Non-Hispanic White children. Similarly 3.2% Black children have a very low birth weight, whereas only 1.2% Non-Hispanic White births are very low birth weight. Therefore, Non-Hispanic Black babies are more than two times as likely to be born with a low or very low birth weight as compared to their Non-Hispanic White peers.

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2018 Dashboard Data Sources

Dashboard	Indicator	Source (Local)	Current Year	Previous Year	Measure (Local)	Time Period	Source (US)	Current Year (US)	Measure (US)	Time Period (US)	Target Source
Chronic Disease	% Women who received Mamogram (50+)*	BRFSS	Unavailable	2010	Percent	3	CDC	Unavailable	Percent	1	HP2020 (C 17)
Chronic Disease	% Colorectal Cancer Screening*	BRFSS	Unavailable	2016	Percent	3	CDC	Unavailable	Percent	1	N/A
Chronic Disease	% Asthma Current Diagnosis*	SCHS	2015	2011	Percent	1	CDC	2015	Percent	1	N/A
Chronic Disease	Stroke Mortality Rate	SCHS	Unavailable	2015	Rate per 100,000	5	CDC	2015	Rate per 100,000	1	HP2020 (HDS-3)
Chronic Disease	Diabetes Mortality Rate	SCHS	2016	2015	Rate per 100,000	55	CDC	2015	Rate per 100,000	1	Hp2020 (D-3): 66.6---but seems really large?
Chronic Disease	Diseases of the Heart Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	HP2020	Unavailable	N/A	1	HP2020 (HDS-2)
Chronic Disease	% Asthma Diagnosis (ever in lifetime)*	SCHS	2015	2010	Percent	1	CDC	2015	Percent	1	N/A
Chronic Disease	Cardiovascular Disease Prevalence	BRFSS	Unavailable	2011	Percent	1	Heart.org	Unavailable	Percent	1	N/A
Chronic Disease	Colorectal Cancer Incidence Rate	SCHS	Unavailable	2015	Rate per 100,000	5	SEER	N/A	Rate per 100,000	5	N/A
Chronic Disease	Colorectal Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	5	HNC2020
Chronic Disease	Prostate Cancer Incidence Rate	SCHS	Unavailable	2015	Rate per 100,000 men	5	SEER	2015	Rate per 100,000 males	5	N/A
Chronic Disease	Prostate Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000 males	5	HP2020
Chronic Disease	Female Breast Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000 women	5	SEER	2015	Rate per 100,000 women	5	HP2020 (C-3)
Chronic Disease	Female Breast Cancer Incidence Rate	SCHS	Unavailable	2015	Rate per 100,000 women	5	SEER	2015	Rate per 100,000 women	5	N/A
Chronic Disease	Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	5	HP2020 (C-1)
Chronic Disease	Cancer Incidence Rate	SCHS	Unavailable	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	7	N/A
Chronic Disease	Lung Cancer Incidence Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	5	N/A
Chronic Disease	Lung Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	5	HP2020 (C-2)
Chronic Disease	% Diabetes Diagnosis, Age Adjusted (20+)	BRFSS	2014	2011	Percent	1	CDC	2015	Percent	1	HNC2020
Chronic Disease	% Asthma Diagnosis (ever in lifetime)*	SCHS	2015	2010	Percent	1	CDC	2015	Percent	1	N/A
Chronic Disease	% Asthma Current Diagnosis*	SCHS	2015	2011	Percent	1	CDC	2015	Percent	1	N/A
Cross-cutting	% Population that is Food Insecure	Unavailable	2016	2014	Percent	1	Feeding America	2016	Percent	1	HP2020
Cross-cutting	Drug Overdose Mortality Rate	Injury Prevention Branch	2016	2015	Rate per 100,000	1	CDC	2016	N/A	N/A	N/A
Cross-cutting	Opioid Overdose Mortality Rate	Injury Prevention Branch	2016	2015	Rate per 100,000	1	CDC	2016	N/A	N/A	N/A
Cross-cutting	Suicide Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	DOT	2015	N/A	1	HNC2020
Cross-cutting	% Crashes that are Alcohol Related	DHHS Annual Report/ Highway Safety Research Center	2016	2015	Percent	3	Previous OC Dashboard	2015	Percent	N/A	HNC2020
Injury and Violence	Violent Crime Rate per 100,000	NC DPS	2016	2015	Rate per 100,000	1	FBI	2016	N/A	1	N/A
Injury and Violence	Assault Rate per 100,000	NC DPS	2016	2015	Rate per 100,000	1	FBI	2016	Rate per 100,000	1	N/A
Injury and Violence	Rape Rate per 100,000	NC DPS	2016	2015	Rate per 100,000	1	FBI	2016	N/A	1	N/A
Injury and Violence	Homicide Rate per 100,000	NC DPS	2016	2015	Rate per 100,000	1	FBI	2016	N/A	1	HP2020
Injury and Violence	Unintentional Motor Vehicle Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	NHTSA	2016	Rate per 100,000	1	N/A
Injury and Violence	Other Unintentional Mortality Rate (Age-Adj)	SCHS	2016	2015	Rate per 100,000	5	HP2020	2015	may include injuries left out in NC measures?	1	N/A
Injury and Violence	Crash Injuries Per 1000 People	NC DPS	2016	2015	Rate per 1,000	3	NHTSA	2016	Rate per 1000	1	HP2020
Injury and Violence	% High schoolers who rode with someone who had been drinking (CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	2015	Percent	1	N/A
Injury and Violence	% High schoolers who texted while driving in past 30 days(CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	2015	Percent	1	N/A
Injury and Violence	% High schoolers who had been injured in a fight (CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	Unavailable	Percent	1	N/A
Injury and Violence	% High schoolers who experienced dating violence (CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	Unavailable	Percent	1	N/A
Injury and Violence	% High schoolers who experienced forced intercourse (CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	Unavailable	Percent	1	N/A
Injury and Violence	% Adults ever experienced traumatic brain injury*	BRFSS	N/A	2011	Percent	1	Scientific American	2012	Percent	1	N/A
Injury and Violence	% Adults who drove after drinking in past 30 days*	BRFSS	N/A	2010	Percent	1	CDC	2010	Percent	1	N/A
Injury and Violence	% High schoolers who rode with someone who had been drinking (OCS)***	YRBS	2016	N/A	Percent	1	MMWR	2015	Percent	1	N/A
Injury and Violence	% High schoolers who texted while driving in past 30 days(OCS)***	YRBS	2016	N/a	Percent	1	MMWR	2015	Percent	1	N/A
Maternal/Infant Health	% Low Birthweight Babies (<2500 grams)*	SCHS	2016	2015	Percent	5	CDC	2015	Percent	1	HP2020 (MICH- 8.1)
Maternal/Infant Health	% Very Low Birthweight Babies (<1500 grams)*	SCHS	2016	2015	Percent	5	CDC	2015	Percent	1	HP2020 (MICH 8.2)
Maternal/Infant Health	% Mothers Smoking while pregnant	SCHS	2016	2015	Percent	5	CDC	2016	Percent	1	HP2020 (MICH- 11.3)
Maternal/Infant Health	% Preterm Births (<37 Wks Gestation)*	SCHS	2016	2015	Percent	5	CDC	2015	percent	1	N/A
Maternal/Infant Health	Infant Mortality Rate (/1,000)	SCHS	2016	2015	Rate per 1,000 Live Births	1	CDC	2015	Rate per 1,000 Births	1	HNC2020
Maternal/Infant Health	Infant Mortality Rate Disparity (AA:White)	SCHS	2016	2015	Rate per 1,000 Live Births	1	CDC	2015	Rate per 1,000 Births	1	HNC2020
Maternal/Infant Health	Teen Pregnancy (Rate/1,000)	SCHS	2016	2015	Rate per 1,000 females	1	CDC	2015	Rate per 1000 females	1	N/A
Maternal/Infant Health	Repeat Teen Pregnancy Rate	SCHS	2016	2015	Percent	5	CDC	2010	Percent	1	N/A
Physical Activity and Nutrition	% Kids in Food Insecure Households	UNC School of Government	2015	2014	Percent	1	UNC School of Government	Unavailable	Percent	1	N/A
Physical Activity and Nutrition	% Adults Physical Inactive	CDC	2015	2014	Percent	3	#N/A	N/A	percent	N/A	arbitrary
Physical Activity and Nutrition	% Adults who are Obese	CDC	2014	2011	Percent	1	Unavailable	2014	Percent	1	arbitrary
SDOH- Access to Care	% Uninsured (<65 years old)	SAHIE	2016	2014	Percent	1	US Census Bureau	2016	Percent	1	N/A
SDOH- Access to Care	% Low-income Uninsured (<65 years old, <200% FPL)	SAHIE	2016	2014	Percent	1	Kaiser Family Foundation	2016	Percent	1	N/A
SDOH- Access to Care	% Children Uninsured (<19 years old)	SAHIE	2016	2014	Percent	1	Kaiser Family Foundation	2016	Percent	1	N/A
SDOH- Access to Care	% Low Income Children Uninsured (<19 years old, <200% FPL)	SAHIE	2016	2014	Percent	1	Kaiser Family Foundation	2016	Percent	1	N/A
SDOH- Access to Care	Physicians Rate per 10,000	SHEPS	2016	2014	Rate per 10,000	1	WHO	2014	Rate per 10,000	1	N/A
SDOH- Access to Care	Dentist Rate per 10,000	SHEPS	2017	2014	Rate per 10,000	1	HRSA	2015	Rate per 10,000	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (EDS) (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (Hispanic) (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (Black) (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (White) (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	% Children Eligible for Free or Reduced Lunch	NC Public Schools	2017	2016	Percent	1	NCES	2013	N/A	1	N/A
SDOH- Poverty Mitigation	% Children Eligible for Free or Reduced Lunch (OCS)	NC Public Schools	2017	2016	Percent	1	NCES	2013	N/A	1	N/A
SDOH- Poverty Mitigation	% Children Eligible for Free or Reduced Lunch (CHCCS)	NC Public Schools	2017	2016	Percent	1	NCES	2013	N/A	1	N/A
SDOH- Poverty Mitigation	Gini Coefficient of Income Inequality (0= most equal, 1.0 = least equal)	ACS	2016	2015	Coefficient	5	US Census Bureau	2016	N/A	5	N/A
SDOH- Poverty Mitigation	% Population living in Poverty	ACS	2016	2015	Percent	5	US Census Bureau	2016	Percent	5	HNC2020
SDOH- Poverty Mitigation	% Children <18 living in Poverty	ACS	2016	2015	Percent	5	US Census Bureau	2016	Percent	5	N/A
SDOH- Poverty Mitigation	% Households on SNAP benefits	ACS	2016	2015	Percent	5	US Census Bureau	2016	Percent	5	N/A
SDOH- Poverty Mitigation	% Unemployed	LAUS	2016	2015	Percent	5	US Census Bureau	2016	N/A	5	N/A
SDOH- Poverty Mitigation	% Renters paying >30% Income on Rent	ACS	2016	2015	Percent	5	US Census Bureau	2016	Percent	5	HNC2020
SDOH- Poverty Mitigation	% Households living with severe housing problems	CDC	2013	N/a	Percent	5	CDC	2013	Percent	5	Unavailable
Sexually Transmitted Infections	Chlamydia Incidence Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HP2020
Sexually Transmitted Infections	Early Syphilis Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HP2020- but broken out by gender...so not comparable
Sexually Transmitted Infections	Gonorrhea Incidence Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HP2020- but broken out by gender...so not comparable
Sexually Transmitted Infections	AIDS Incidence Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HP2020- since archieved due to policy change
Sexually Transmitted Infections	HIV Infection Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HNC2020
Substance Use and Mental Health	Alzheimer's Age-Adj Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	CDC	2015	N/A	N/A	N/A
Substance Use and Mental Health	% Adults who Drink Excessively (Binge Drinking)*	BRFSS	2011	2011	Percent	1	NIH	2016	Percent	N/A	N/A
Substance Use and Mental Health	% High schoolers who smoked in past 30 days (CHCCS)**	YRBS	2017	2015	Percent	1	US YRBS	2015	Percent	1	HP2020
Substance Use and Mental Health	% High schoolers who have ever used an e-cigarette (CHCCS)**	YRBS	2017	2015	Percent	1	US YRBS	2015	Percent	1	HP2020
Substance Use and Mental Health	% High schoolers who believe vape is low harm (CHCCS)**	YRBS	2017	2015	Percent	1	US YRBS	N/A	Percent	1	HP2020
Substance Use and Mental Health	% High schoolers who have used marijuana in past 30 days (CHCCS)**	YRBS	2017	2015	Percent	1	US YRBS	2015	Percent	1	HP2020
Substance Use and Mental Health	% High schoolers using alcohol products (CHCCS)**	YRBS	2015	2015	Percent	1	Previous OC Dashboard	2015	Percent	1	Previous Target
Substance Use and Mental Health	% Exposed to Secondhand Smoke at Work*	BRFSS	2016	2010	Percent	5	#N/A	Unavailable	N/A	N/A	HNC2020
Substance Use and Mental Health	% Adult Smokers*	SCHS	N/a	2011	Percent	1	#N/A	2016	Percent	1	HNC2020
Substance Use and Mental Health	% Older Adults with Depression	CMS	2016	2015	Percent	1	CMS	2016	Percent	1	N/A
Substance Use and Mental Health	% Providers registered in CSRS	Previous OCHD Report	2016	N/A	Percent	N/A	#N/A	N/A	N/A	N/A	N/A
Substance Use and Mental Health	% High schoolers who have ever used an e-cigarette (OCS)***	YRBS	2016	N/A	Percent	1	US YRBS	2015	Percent	1	HP2020
Substance Use and Mental Health	% Adults who Drink Excessively (Binge Drinking)*	BRFSS	2011	2011	Percent	1	NIH	2016	Percent	N/A	N/A
Substance Use and Mental Health	% Older Adults with Depression	CMS	2016	2015	Percent	1	CMS	2016	Percent	1	N/A
Substance Use and Mental Health	% Providers registered in CSRS	Previous OCHD Report	2016	N/A	Percent	N/A	#N/A	N/A	N/A	N/A	N/A
Substance Use and Mental Health	Alzheimer's Age-Adj Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	CDC	2015	N/A	N/A	N/A

Public Health Dashboards:

Purpose:

To provide an executive level view of how the county is performing on indicators in major public health content areas as compared to the state, nation, peers, and available targets or goals. Icons provide quick reference to indicators of note, and how Orange County compares to these benchmarks.

Content Areas:

Access to Care; Chronic Disease; Injury and Violence; Maternal and Infant Health; Physical Activity and Nutrition; Poverty Mitigation; Sexually Transmitted Diseases; Substance Use and Mental Health; Tobacco and Respiratory Disease;

Data Disclaimer:

These dashboards are intended to be a starting point for collecting a number of related indicators in one place. However, because these data come from a variety of different data sources, each indicator will have its own set of limitations and considerations based on the collection and analysis methodology for that data source. It is important to understand the methodology utilized for the indicators you may be interested in and incorporate corresponding limitations into any of your own reporting. References and/or more detailed information on the sources for particular data points are provided in summary at the end of this document, and additional information may be provided on request.

FAQs:

Q: What sources do you use for your data?

These dashboards use the most recent and available data and statistics from a variety of different sources. Some of these data sources include:

American Community Survey (ACS) from the Census Bureau;
Behavioral Risk Factor Surveillance Survey (BRFSS);
The Cecil G. Sheps Center for Health Services Research (Sheps Center);
Center for Disease Control and Prevention (CDC);
Department of Health and Human Services (DHHS);
Henry J. Kaiser Family Foundation
Morbidity and Mortality Weekly Report and Statistics (MMWR);
National Center for Education Statistics (NCES);
NC Controlled Substance Reporting System (CSRS);
North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT);
North Carolina Electronic Disease Surveillance System (NC EDSS);
North Carolina Public Schools;
North Carolina State Department of Public Safety (NC DPS) and Bureau of Investigation (NCSBI);
North Carolina State Center for Health Statistics (NC SCHS);
North Carolina Department of Transportation (NC DOT)
Pediatric Nutrition Surveillance System (PedNSS);
Small Area Health Insurance Estimates (SAHIE);
Surveillance, Epidemiology, and End Results Program (SEER) through The National Cancer Institute;
UNC School of Government Hunger Research;
Youth Risk Behavior Survey (YRBS);

Q: What years are your data from?

The data included in these dashboards are the most up to date data available for Orange County. In some cases, there may be more recent data available for peers, the state, or the US; however, benchmark values are selected from the same year as the Orange County data, for consistency of comparison. In some cases, data points from one geography may represent multiple year rates (such as 3-year or 5-year rates), whereas other geographies may show only 1-year rates. In these cases, the smaller geography (counties) uses multiple years of data to improve statistical power through a larger sample size, whereas US numbers are large enough in a single year to report a 1-year rate.

Q: How do you determine which indicators to include in your dashboards?

The over-arching content areas selected for our dashboards are based on current county priority areas and on the topic area categories included in the Healthy People 2020 and Healthy North Carolina 2020 Objectives. In order to present a meaningful set of data that develops an executive level picture for what is happening in our county's health, we only include indicators that meet several criteria. These criteria help contextualize county measures by relating them to comparable benchmarks. Meaning, a number by itself does not give you any frame of reference unless you have other measures to compare it with.

We aim to select measures that are **meaningful** to public health and:

1) **annual** measures
2) **updated** on a regular basis
3) available at the **county level**
4) have **existing objectives, targets, or benchmarks** (such as the HP2020 or HNC2020 Objectives)
5) are **commonly used measures across geographies** (other counties, the state, the US)

In some cases, an indicator may meet several but not all of these criteria. In general, an indicator must meet a majority of these criteria to be included in the dashboard.

Q: What do the circle, triangle, and square icons mean?

- Performing better than four or more benchmarks
- Performing better than two or three benchmarks
- Performing better than one or no benchmarks

Benchmarks include Target, Previous, Peer, NC, and US

The performance icons serve as "at-a-glance" guides that allow the reader to scan the dashboard and identify indicators for which the county is performing either better or worse than the majority of available benchmarks (target, previous, peer, NC and US).

It is important to note that these icons serve as a starting point for conversations, but there are many stories to tell behind each indicator. For example, an indicator with a green circle may not alert the reader to health disparities for a specific demographic group within an indicator data set. The absence of disparity measures is a general limitation of this indicator set, but the department hopes to incorporate more data related to health disparities in future dashboard iterations.

Q: How do you determine whether a trend is increasing, decreasing, or the same?

↑↓	Positive trend		Significant change from previous
↑↓	Negative trend		
SAME	No trend		
-	Trend can not be assessed		

As most of these indicators currently only observe two data points in time, it is difficult to identify a true change in trend (a second limitation of this data set). Observing whether confidence intervals or margins of error for the two observed values overlap from one year to another represents the best method for determining if there is a statistical difference between previous and current indicator values. However, confidence intervals are not always readily available in reports. In addition, when there are changes is survey or data reporting methodology, current measures may not be comparable to previous years. In these cases, it is indicated that the trend can not be assessed.

For the purposes of this dashboard, we have adopted four "rules of thumb" for identifying a threshold for change in trend, as well as if that change appears significant, in the absence of confidence intervals or margin of error.

- **A difference of one percentage point or greater from a surveyed population (such as BRFSS/YRBS, represented by a percentage value) is deemed as a change in trend.** For example, a change from 7.0% to 8.4% would represent an increasing trend, whereas a change from 7.0% to 7.8% would be considered the same. Whether this trend is "positive" or "negative" (signified by green or red colors) depends on the nature of the indicator. If we are observing an increase in diabetes that would be a negative trend, but an increase in physical activity would be a positive trend.

- **A difference in a rate that represents a 1% increase or decrease of the previous rate value when expressed as a percentage would also be deemed as a change in trend.** For example, a rate difference from 3.1 to 2.7 per 100,000 people would represent a -12.9% difference (3.1-2.7= .4/3.1 = .129). This would represent a decrease in trend. However, a rate difference from 256.3 to 255.9 per 100,000 people would only represent a -0.2% difference (rounded), and would thus be considered the same as the previous year for the purposes of this dashboard (256.3-255.9= .4/256.3 = .0016).

- **For rates greater than 5, green and red fill backgrounds signify a greater than 20% increase or decrease** in rate from previous, noted in this case as a significant change in trend from previous. For example, a rate difference from 3.1 to 2.7 per 100,000 people would represent a -12.9% difference (3.1-2.7= .4/3.1 = .129). This would represent a decrease in trend. However, a rate difference from 256.3 to 255.9 per 100,000 people would only represent a -0.2% difference (rounded), and would thus be considered the same as the previous year for the purposes of this dashboard (256.3-255.9= .4/256.3 = .0016).

- **A difference in a rate that represents a 5% increase or decrease of the previous rate value when expressed as a percentage would also be deemed as a significant change in trend.**

For Additional Information:

If you have any questions or comments regarding the methodology and/or data contained in these dashboards, please contact Allison Young, Health Informatics Manager, at ayoung@orangecountync.gov.

Data Source Considerations

American Community Survey (ACS) from the Census Bureau

Source: Urban Institute

The American Community Survey (ACS) is an ongoing statistical survey run by the U.S. Census Bureau, replacing the long form in the decennial census. The ACS has approximately 250,000 respondents monthly, totaling 3 million per year. ACS data are particularly useful, as it is publicly available and offers indicators on several topics.

Frequency: Survey data are collected regularly. Because the ACS covers a smaller sample size than the decennial census, these data files come in one-year, three-year, and five-year averages. For example, data from the 2008–2010 sample will represent averages over the 36-month span.

Geographies: Census tracts, county subdivisions, zip code tabulation areas, counties. Only the five-year averages have data down to the census tract level.

Variables: ACS data are collected on both persons/households and housing characteristics. Data on persons/households includes age, sex, ancestry or immigration status, disability, work commutes, education, employment, family composition, income, language, poverty, and race/ethnicity. Data on housing include financial characteristics such as rent and mortgage costs, as well as physical characteristics such as the number of units in the building and the age of the housing unit.

Strengths: Compared to the decennial census, ACS data are available on more topics and are updated more frequently.

Drawbacks: Because of the smaller ACS sample sizes, users must pay special attention to standard errors, as they can be particularly large. In addition, when using data that represent multiyear averages, users are advised to not compare overlapping years (e.g., 2005–2009 data should not be compared to 2006–2010 data).

Additional Information: The Census Bureau has created a useful guide for ACS data (http://www.census.gov/acs/www/Downloads/handbooks/ACSResearch.pdf).

Data Availability: Data can be downloaded for specific geographies using FactFinder (http://factfinder2.census.gov/), or flat files can be downloaded for multiple areas (http://www.census.gov/acs/www/data_documentation/data_via_ftp/)

Decennial Census

Source: Urban Institute

Prior to 2010, the decennial census included basic information on the 100 percent sample (Summary File 1, or SF1) as well as detailed information on a subset of the population receiving the long form, which includes additional questions. Beginning in 2010, the decennial census only provides data on basic demographic information (SF1), as the long form has been replaced by the American Community Survey (ACS) discussed below.

Frequency: Every 10 years.
Geographies: Blocks, block groups, census tracts, counties, county subdivisions, zip code tabulation areas.
Variables: Total population, age, sex, race and ethnicity, household type, tenure, vacancy.

Strengths: Data are available at small geographies (down to the block level). Data come from a census rather than a sample survey, with results in smaller margins of error.
Drawbacks: Because the decennial census occurs only once every 10 years, its data quickly become outdated. Data are limited to a small set of variables.

Additional Information: The Census Bureau may draw new geographic boundaries for a new decennial census. Consequently, when using the decennial census from multiple years, Promise Neighborhoods must first ascertain that geographic boundaries have not changed. Moreover, the decennial census can change how a question is phrased, which might change the indicator over time. (For example, in 2010 the Census Bureau changed how it asked respondents about race and ethnicity.) Because of this, data might not be comparable from year to year or between the decennial census and the ACS (discussed below). Users should check the Census Bureau web site (http://2010.census.gov/2010census/) for any changes in phrasing and their effects on comparability.

Data Availability: Data for specific geographies can be found using FactFinder (http://factfinder2.census.gov).

2018 Dashboard Data Sources

Dashboard	Indicator	Source (Local)	Current Year	Previous Year	Measure (Local)	Time Period	Source (US)	Current Year (US)	Measure (US)	Time Period (US)	Target Source
Chronic Disease	% Women who received Mamogram (50+)*	BRFSS	Unavailable	2010	Percent	3	CDC	Unavailable	Percent	1	HP2020 (C 17)
Chronic Disease	% Colorectal Cancer Screening*	BRFSS	Unavailable	2016	Percent	3	CDC	Unavailable	Percent	1	N/A
Chronic Disease	% Asthma Current Diagnosis*	SCHS	2015	2011	Percent	1	CDC	2015	Percent	1	N/A
Chronic Disease	Stroke Mortality Rate	SCHS	Unavailable	2015	Rate per 100,000	5	CDC	2015	Rate per 100,000	1	HP2020 (HDS-3)
Chronic Disease	Diabetes Mortality Rate	SCHS	2016	2015	Rate per 100,000	55	CDC	2015	Rate per 100,000	1	Hp2020 (D-3): 66.6---but seems really large?
Chronic Disease	Diseases of the Heart Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	HP2020	Unavailable	N/A	1	HP2020 (HDS-2)
Chronic Disease	% Asthma Diagnosis (ever in lifetime)*	SCHS	2015	2010	Percent	1	CDC	2015	Percent	1	N/A
Chronic Disease	Cardiovascular Disease Prevalence	BRFSS	Unavailable	2011	Percent	1	Heart.org	Unavailable	Percent	1	N/A
Chronic Disease	Colorectal Cancer Incidence Rate	SCHS	Unavailable	2015	Rate per 100,000	5	SEER	N/A	Rate per 100,000	5	N/A
Chronic Disease	Colorectal Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	5	HNC2020
Chronic Disease	Prostate Cancer Incidence Rate	SCHS	Unavailable	2015	Rate per 100,000 men	5	SEER	2015	Rate per 100,000 males	5	N/A
Chronic Disease	Prostate Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000 males	5	HP2020
Chronic Disease	Female Breast Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000 women	5	SEER	2015	Rate per 100,000 women	5	HP2020 (C-3)
Chronic Disease	Female Breast Cancer Incidence Rate	SCHS	Unavailable	2015	Rate per 100,000 women	5	SEER	2015	Rate per 100,000 women	5	N/A
Chronic Disease	Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	5	HP2020 (C-1)
Chronic Disease	Cancer Incidence Rate	SCHS	Unavailable	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	7	N/A
Chronic Disease	Lung Cancer Incidence Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	5	N/A
Chronic Disease	Lung Cancer Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	SEER	2015	Rate per 100,000	5	HP2020 (C-2)
Chronic Disease	% Diabetes Diagnosis, Age Adjusted (20+)	BRFSS	2014	2011	Percent	1	CDC	2015	Percent	1	HNC2020
Chronic Disease	% Asthma Diagnosis (ever in lifetime)*	SCHS	2015	2010	Percent	1	CDC	2015	Percent	1	N/A
Chronic Disease	% Asthma Current Diagnosis*	SCHS	2015	2011	Percent	1	CDC	2015	Percent	1	N/A
Cross-cutting	% Population that is Food Insecure	Unavailable	2016	2014	Percent	1	Feeding America	2016	Percent	1	HP2020
Cross-cutting	Drug Overdose Mortality Rate	Injury Prevention Branch	2016	2015	Rate per 100,000	1	CDC	2016	N/A	N/A	N/A
Cross-cutting	Opioid Overdose Mortality Rate	Injury Prevention Branch	2016	2015	Rate per 100,000	1	CDC	2016	N/A	N/A	N/A
Cross-cutting	Suicide Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	DOT	2015	N/A	1	HNC2020
Cross-cutting	% Crashes that are Alcohol Related	DHHS Annual Report/ Highway Safety Research Center	2016	2015	Percent	3	Previous OC Dashboard	2015	Percent	N/A	HNC2020
Injury and Violence	Violent Crime Rate per 100,000	NC DPS	2016	2015	Rate per 100,000	1	FBI	2016	N/A	1	N/A
Injury and Violence	Assault Rate per 100,000	NC DPS	2016	2015	Rate per 100,000	1	FBI	2016	Rate per 100,000	1	N/A
Injury and Violence	Rape Rate per 100,000	NC DPS	2016	2015	Rate per 100,000	1	FBI	2016	N/A	1	N/A
Injury and Violence	Homicide Rate per 100,000	NC DPS	2016	2015	Rate per 100,000	1	FBI	2016	N/A	1	HP2020
Injury and Violence	Unintentional Motor Vehicle Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	NHTSA	2016	Rate per 100,000	1	N/A
Injury and Violence	Other Unintentional Mortality Rate (Age-Adj)	SCHS	2016	2015	Rate per 100,000	5	HP2020	2015	may include injuries left out in NC measures?	1	N/A
Injury and Violence	Crash Injuries Per 1000 People	NC DPS	2016	2015	Rate per 1,000	3	NHTSA	2016	Rate per 1000	1	HP2020
Injury and Violence	% High schoolers who rode with someone who had been drinking (CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	2015	Percent	1	N/A
Injury and Violence	% High schoolers who texted while driving in past 30 days(CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	2015	Percent	1	N/A
Injury and Violence	% High schoolers who had been injured in a fight (CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	Unavailable	Percent	1	N/A
Injury and Violence	% High schoolers who experienced dating violence (CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	Unavailable	Percent	1	N/A
Injury and Violence	% High schoolers who experienced forced intercourse (CHCCS)**	YRBS	2017	2015	Percent	1	MMWR	Unavailable	Percent	1	N/A
Injury and Violence	% Adults ever experienced traumatic brain injury*	BRFSS	N/A	2011	Percent	1	Scientific American	2012	Percent	1	N/A
Injury and Violence	% Adults who drove after drinking in past 30 days*	BRFSS	N/A	2010	Percent	1	CDC	2010	Percent	1	N/A
Injury and Violence	% High schoolers who rode with someone who had been drinking (OCS)***	YRBS	2016	N/A	Percent	1	MMWR	2015	Percent	1	N/A
Injury and Violence	% High schoolers who texted while driving in past 30 days(OCS)***	YRBS	2016	N/a	Percent	1	MMWR	2015	Percent	1	N/A
Maternal/Infant Health	% Low Birthweight Babies (<2500 grams)*	SCHS	2016	2015	Percent	5	CDC	2015	Percent	1	HP2020 (MICH- 8.1)
Maternal/Infant Health	% Very Low Birthweight Babies (<1500 grams)*	SCHS	2016	2015	Percent	5	CDC	2015	Percent	1	HP2020 (MICH 8.2)
Maternal/Infant Health	% Mothers Smoking while pregnant	SCHS	2016	2015	Percent	5	CDC	2016	Percent	1	HP2020 (MICH- 11.3)
Maternal/Infant Health	% Preterm Births (<37 Wks Gestation)*	SCHS	2016	2015	Percent	5	CDC	2015	percent	1	N/A
Maternal/Infant Health	Infant Mortality Rate (/1,000)	SCHS	2016	2015	Rate per 1,000 Live Births	1	CDC	2015	Rate per 1,000 Births	1	HNC2020
Maternal/Infant Health	Infant Mortality Rate Disparity (AA:White)	SCHS	2016	2015	Rate per 1,000 Live Births	1	CDC	2015	Rate per 1,000 Births	1	HNC2020
Maternal/Infant Health	Teen Pregnancy (Rate/1,000)	SCHS	2016	2015	Rate per 1,000 females	1	CDC	2015	Rate per 1000 females	1	N/A
Maternal/Infant Health	Repeat Teen Pregnancy Rate	SCHS	2016	2015	Percent	5	CDC	2010	Percent	1	N/A
Physical Activity and Nutrition	% Kids in Food Insecure Households	UNC School of Government	2015	2014	Percent	1	UNC School of Government	Unavailable	Percent	1	N/A
Physical Activity and Nutrition	% Adults Physical Inactive	CDC	2015	2014	Percent	3	#N/A	N/A	percent	N/A	arbitrary
Physical Activity and Nutrition	% Adults who are Obese	CDC	2014	2011	Percent	1	Unavailable	2014	Percent	1	arbitrary
SDOH- Access to Care	% Uninsured (<65 years old)	SAHIE	2016	2014	Percent	1	US Census Bureau	2016	Percent	1	N/A
SDOH- Access to Care	% Low-income Uninsured (<65 years old, <200% FPL)	SAHIE	2016	2014	Percent	1	Kaiser Family Foundation	2016	Percent	1	N/A
SDOH- Access to Care	% Children Uninsured (<19 years old)	SAHIE	2016	2014	Percent	1	Kaiser Family Foundation	2016	Percent	1	N/A
SDOH- Access to Care	% Low Income Children Uninsured (<19 years old, <200% FPL)	SAHIE	2016	2014	Percent	1	Kaiser Family Foundation	2016	Percent	1	N/A
SDOH- Access to Care	Physicians Rate per 10,000	SHEPS	2016	2014	Rate per 10,000	1	WHO	2014	Rate per 10,000	1	N/A
SDOH- Access to Care	Dentist Rate per 10,000	SHEPS	2017	2014	Rate per 10,000	1	HRSA	2015	Rate per 10,000	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (EDS) (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (Hispanic) (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (Black) (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	4 year Graduation Rate (White) (%)	NC Public Schools/ NCES	2017	2016	Percent	1	NCES	2016	Percent	1	N/A
SDOH- Poverty Mitigation	% Children Eligible for Free or Reduced Lunch	NC Public Schools	2017	2016	Percent	1	NCES	2013	N/A	1	N/A
SDOH- Poverty Mitigation	% Children Eligible for Free or Reduced Lunch (OCS)	NC Public Schools	2017	2016	Percent	1	NCES	2013	N/A	1	N/A
SDOH- Poverty Mitigation	% Children Eligible for Free or Reduced Lunch (CHCCS)	NC Public Schools	2017	2016	Percent	1	NCES	2013	N/A	1	N/A
SDOH- Poverty Mitigation	Gini Coefficient of Income Inequality (0= most equal, 1.0 = least equal)	ACS	2016	2015	Coefficient	5	US Census Bureau	2016	N/A	5	N/A
SDOH- Poverty Mitigation	% Population living in Poverty	ACS	2016	2015	Percent	5	US Census Bureau	2016	Percent	5	HNC2020
SDOH- Poverty Mitigation	% Children <18 living in Poverty	ACS	2016	2015	Percent	5	US Census Bureau	2016	Percent	5	N/A
SDOH- Poverty Mitigation	% Households on SNAP benefits	ACS	2016	2015	Percent	5	US Census Bureau	2016	Percent	5	N/A
SDOH- Poverty Mitigation	% Unemployed	LAUS	2016	2015	Percent	5	US Census Bureau	2016	N/A	5	N/A
SDOH- Poverty Mitigation	% Renters paying >30% Income on Rent	ACS	2016	2015	Percent	5	US Census Bureau	2016	Percent	5	HNC2020
SDOH- Poverty Mitigation	% Households living with severe housing problems	CDC	2013	N/a	Percent	5	CDC	2013	Percent	5	Unavailable
Sexually Transmitted Infections	Chlamydia Incidence Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HP2020
Sexually Transmitted Infections	Early Syphilis Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HP2020- but broken out by gender...so not comparable
Sexually Transmitted Infections	Gonorrhea Incidence Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HP2020- but broken out by gender...so not comparable
Sexually Transmitted Infections	AIDS Incidence Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HP2020- since archieved due to policy change
Sexually Transmitted Infections	HIV Infection Rate (/100,000)	DHHS	2016	2014	Rate per 100,000	1	CDC	2016	Rate per 100,000	1	HNC2020
Substance Use and Mental Health	Alzheimer's Age-Adj Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	CDC	2015	N/A	N/A	N/A
Substance Use and Mental Health	% Adults who Drink Excessively (Binge Drinking)*	BRFSS	2011	2011	Percent	1	NIH	2016	Percent	N/A	N/A
Substance Use and Mental Health	% High schoolers who smoked in past 30 days (CHCCS)**	YRBS	2017	2015	Percent	1	US YRBS	2015	Percent	1	HP2020
Substance Use and Mental Health	% High schoolers who have ever used an e-cigarette (CHCCS)**	YRBS	2017	2015	Percent	1	US YRBS	2015	Percent	1	HP2020
Substance Use and Mental Health	% High schoolers who believe vape is low harm (CHCCS)**	YRBS	2017	2015	Percent	1	US YRBS	N/A	Percent	1	HP2020
Substance Use and Mental Health	% High schoolers who have used marijuana in past 30 days (CHCCS)**	YRBS	2017	2015	Percent	1	US YRBS	2015	Percent	1	HP2020
Substance Use and Mental Health	% High schoolers using alcohol products (CHCCS)**	YRBS	2015	2015	Percent	1	Previous OC Dashboard	2015	Percent	1	Previous Target
Substance Use and Mental Health	% Exposed to Secondhand Smoke at Work*	BRFSS	2016	2010	Percent	5	#N/A	Unavailable	N/A	N/A	HNC2020
Substance Use and Mental Health	% Adult Smokers*	SCHS	N/a	2011	Percent	1	#N/A	2016	Percent	1	HNC2020
Substance Use and Mental Health	% Older Adults with Depression	CMS	2016	2015	Percent	1	CMS	2016	Percent	1	N/A
Substance Use and Mental Health	% Providers registered in CSRS	Previous OCHD Report	2016	N/A	Percent	N/A	#N/A	N/A	N/A	N/A	N/A
Substance Use and Mental Health	% High schoolers who have ever used an e-cigarette (OCS)***	YRBS	2016	N/A	Percent	1	US YRBS	2015	Percent	1	HP2020
Substance Use and Mental Health	% Adults who Drink Excessively (Binge Drinking)*	BRFSS	2011	2011	Percent	1	NIH	2016	Percent	N/A	N/A
Substance Use and Mental Health	% Older Adults with Depression	CMS	2016	2015	Percent	1	CMS	2016	Percent	1	N/A
Substance Use and Mental Health	% Providers registered in CSRS	Previous OCHD Report	2016	N/A	Percent	N/A	#N/A	N/A	N/A	N/A	N/A
Substance Use and Mental Health	Alzheimer's Age-Adj Mortality Rate	SCHS	2016	2015	Rate per 100,000	5	CDC	2015	N/A	N/A	N/A

ORANGE COUNTY HEALTH DEPARTMENT MISSION STATEMENT: *To enhance the quality of life, promote the health, and preserve the environment for all people in the Orange County community.*

THE ORANGE COUNTY BOARD OF HEALTH MET ON April 25, 2018 at the Orange County Health Department, 300 West Tryon Street, Hillsborough, NC.

BOARD OF HEALTH MEMBERS PRESENT: , Timothy Smith –Vice-Chair, Bruce Baldwin Johanna Birchmayer, Paul Chelminski, Jennifer Deyo, Jessica Frega and Liska Lackey.

BOARD OF HEALTH MEMBERS ABSENT: Susan Elmore, Commissioner Mia Burroughs, Barbara Chavious and Sam Lasris.

STAFF PRESENT: Quintana Stewart, Health Director; Coby Jansen Austin, Director of Programs and Policy; Rebecca Crawford, Financial and Administrative Services Director; Victoria Hudson, Interim Environmental Health Director; Donna King, Health Promotion & Education Services Director; Kristin Prelipp, Communications Manager; Ana Salas, Dental Assistant; La Toya Strange, Administrative Assistant II; and Phil Vilaro, Interim Environmental Health Director.

GUESTS PRESENT: None

I. Welcome New Employees

Timothy Smith, Vice-Chair, called the meeting to order. There were no new employees in attendance.

II. Public Comment for Items NOT on Printed Agenda: None.

III. Approval of the April 25, 2018 Agenda

Motion was made by Jennifer Deyo to approve the agenda, seconded by Paul Chelminski and carried without dissent.

IV. Action Items (Consent)

A. Minutes of March 28, 2018 Meeting

Motion was made by Liska Lackey to approve the minutes of March 2018, seconded by Jessica Frega and carried without dissent.

V. Educational Sessions

A. Opioid Update

Board of Health member and Professor of Medicine at UNC, Dr. Paul Chelminski, gave an

excellent presentation of an overview of the national and local opioid crisis titled "Opioid Epidemic: Collisions at the Crossroads". Below are some of the highlights.

- Opioids are prescribed for moderate to severe pain, particularly chronic pain.
- Chronic pain is recognized as another important public health problem that is often undertreated.
- Key factors that led to the rise in the prescribing and consuming of opioids
  - The intent to cure pain
  - Wide acceptance that opioid painkillers were low-risk and non-addictive
  - Lack of experience in opioid addiction science
- It was learned, early on, that you can't identify a drug misuser. It's difficult to determine who is a straight shooter vs a misuser without defining unacceptable behaviors that misusers exhibit such as cocaine in urine and doctor shopping.
- The Joint Commission required physicians to ask patients to rate the amount of pain they're experiencing. This leads to the option of patient function vs pain score to determine the patient's pain level.
- The decision of whether and how providers should use opioids in a primary care setting falls largely on expert opinion and clinical judgment.
- Chronic pain has been found to be interconnected to mental illness and substance misuse of which 60-80% of people experience depression or anxiety. There is limited literature available that addresses this issue and most of it is incredibly flawed.
- Admissions for prescription opioid abuse treatment escalated more than 5 fold from 35,648 in 2001 to 180,708 in 2011.
- In 2016, the prescribing rate for opioids was 61 prescriptions per 100 persons. During this time, there was also a huge increase in opioid misuse in urban areas.
- In 2016, around 64,000 people died from drug overdoses in the U.S.
- The opioid crisis is not a Caucasian epidemic; it just started there, primarily in the Appalachian area. It then, eventually, spread to the African-American and Native American communities.
- Every 25 minutes a baby is born with opioids in their system and suffers opioid withdrawal.
- The prescribing of opioids has decreased; however, fentanyl prescription has increased. Fentanyl is 100 times more potent than opioids.
- Although opioid deaths and the prescribing began to decrease in 2010, they're starting to spike again.
- Besides public health, there are clinical and mental health dimensions to the opioid crisis.
- Some remedies to address the epidemic include naloxone, CDC guidelines, mental health reform and prescription monitor programs (PMPs).

The BOH had questions that were addressed by Dr. Chelminski.

B.&C. 3rd Quarter Billing Dashboard and Financial Reports

Rebecca Crawford, Financial & Administrative Services Director, gave a report on the 3rd quarter revenue and billing accuracy. The report is as follows:

- Total Health Department Revenue: Average YTD monthly revenue in FY18 after the third quarter is $211/month and totals $2.1M YTD, representing 61.2% of our overall budgeted revenue for the year. The total third quarter revenue is slightly skewed down due to the majority of state funds not eligible to be drawn in July (this is typical) but we

are trending higher than we were at this time last fiscal year ($1.9M). Expenses are higher than revenues at 66.2% of the total, overall budget.

- Total Billing Accuracy: Continuing with the goal of 90% billing accuracy set in FY 14-15, the average billing accuracy rate for medical after the third quarter is 89% as compared to 96% in FY 16-17 and the average rate for dental for third quarter FY 17-18 is 101% as compared to 98% in FY 16-17.

- Dental Earned Revenue by Source: The FY 17-18 average monthly revenue ($40.9/month) for the third quarter is below our budget projection ($43.4k/month) but above our FY 16-17 average of $39.8k/month. FY 17-18 dental earned revenue totaled $381k at the end of the third quarter.

- Medical Earned Revenue by Source**:** Medical earned revenue is currently below the budgeted projection for FY 17-18 ($57.1k/month) at $51.6k/month since we had a provider on maternity leave until the end of December. Medical clinic revenue totals $469k for third quarter FY 17-18.

D. Advisory Board Update

Donna King, Health Promotion and Education Services, stepped in for Beverly Scurry, Board of Health Strategic Plan Manager, and informed the Board members to email Ms. Scurry if there are any questions regarding the Advisory Board Update. She also reminded them to complete the Doodle Poll regarding subcommittee meetings. Updating the BOH Strategic Plan will be discussed. Any Board members that need help attending an REI training were encouraged to reach out to Ms. Scurry.

VI. Action Items (Non Consent)

A. Board Reappointments

Timothy Smith, Co-Chair, conveyed that there were four Board members whose term will be ending soon. The Board of Health will vote to recommend Bruce Baldwin to his 1st full term; Barbara Chavious to her 2nd full term; Timothy Smith to his 2nd full term; and Johanna Birckmayer to her 1st full term. Mr. Smith mentioned that, when voting, those that are up for reappointment, must recuse themselves.

Motion to reappoint Bruce Baldwin was made by Paul Chelminksi, seconded by Liska Lackey, and carried without dissent.

Motion to reappoint Barbara Chavious was made by Jennifer Deyo, seconded by Johanna Birckmayer, and carried without dissent.

Motion to reappoint Timothy Smith was made by Jessica Frega, seconded by Jessica Frega, and carried without dissent.

Motion to reappoint Johanna Birckmayer was made by Jessica Frega, seconded by Jennifer Deyo, and carried without dissent.

B. Fee Change

Both the Medical and Dental clinics request to add fees outside of the normal process. Rebecca Crawford reviewed those proposed fee changes which were:

Dental Clinic
The Dental Clinic was awarded a grant from Delta Dental for $2,000 and have elected to use the funding to treat childhood caries by the Silver Diamine Fluoride technique, which requires the Health Department to add an associated fee to the fee schedule. We anticipate treating 75 Medicaid eligible children between the ages of 1 and 8 during the term of the grant, which will end August 31, 2018. Based on our analysis of costs to perform the procedure and fees from surrounding jurisdictions, we propose to set the fee at $49. Given that the Medicaid reimbursement rate is $24.18 for this procedure, we only anticipate receiving $1,813.50 in revenue. The proposed change is detailed below:

Name of Fee	2017-18 Current Fee	2017-18 Proposed Fee	2017-18 Budget Impact
Silver Diamine Fluoride (D1354)	$0	$49	$1,813.50

Medical Clinic
The Medical clinic recommends this new addition to our Fee Schedule due to the recent introduction on the market of the new Shingles vaccine - Shingrix. This vaccine will keep the Orange County Health Department Clinic up to date with the newest vaccines available, it will provide the residents of Orange County with the opportunity to receive protection against the Varicella Zoster Virus and it will keep our clinic relevant and able to meet the newest federal guidelines on vaccinations of people 50 years old or above. We anticipate administering five Shingrix vaccines per year and will charge our cost to purchase the vaccine, $138.60, which would potentially result in $693 in revenue.

Name of Fee	2017-18 Current Fee	2017-18 Proposed Fee	2017-18 Budget Impact
Shingrix Vaccine (90750)	$0	$138.60	$693

The BOH members had questions that were answered by Ms. Crawford.

Motion was made by Jessica Frega to approve the proposed fee changes for 2017-2018 as presented and forward to the Board of County Commissioners for action, seconded by Paul Chelminski and carried without dissent.

VII. Reports and Discussion with Possible Action

A. Health Director Report

In addition to the report, Ms. Stewart briefly expounded upon the 3 conferences that she attended. The Annual Health Director's Public Health Legal Conference had a key presentation on the opioid crisis. Guilford County and UNC at Greensboro have created a community-engaged response to the opioid problem in which all of the agencies that deal with the opioid crisis, law enforcement, EMS, medical professionals and psychologists team up to help addicts using a unified treatment plan. Many counties want to emulate their plan.

The Equity Summit was a great conference with awesome speakers. Kristin Prelipp,

Communications Manager, is working on a presentation that will be shown to the Board members next month. Ms. Stewart presented at the National Preparedness Summit. It also gave focus to the special needs/vulnerable population which is sometimes overlooked.

Ms. Stewart also spoke briefly on the Institute of Public Health "Crafting Richer Messengers: The Public Health Advantage" workshop she attended today. She was invited by Gene Matthews, NC Institute for Public Health. There was some emphasis on how to reach non-traditional audiences and usage of more liberal type messages to help reach the conservative population.

The BOH members had questions that were answered by Ms. Stewart.

B. Media Items

Kristin Prelipp, Communications Manager, briefly mentioned the article topics of OC Health Rankings, the FSA, PrEP and ICE raids that were included in the Media Items packet. Media items were in the packet which focused on Orange County's events and our involvement in various efforts.

VIII. Board Comments

None.

IX. Adjournment

Jessica Frega moved to adjourn the meeting at 8:00pm and Paul Chelminski seconded.

The next Board of Health Meeting will be held May 23, 2018 at the Orange County Health Department, 300 West Tryon Street, Hillsborough, NC at 7:00 p.m.

Respectfully submitted,

Quintana Stewart, MPA
Orange County Health Director
Secretary to the Board

DRAFT

Health Director's Report
May 2018

- May 2018 – Continue to have bi-weekly 1-on-1 meetings with Division Directors to discuss and address program specific challenges.
- May 2, 2018 – Completed County Telework Training to understand the County Policy and to ensure implementation consistently across the department.
- May 14, 2018 – Meeting about renovations to Southern Human Campus
- May 15, 2018 – Attended New Health Director Orientation in Raleigh, NC sponsored by NC Association of Local Health Directors
- May 16, 2018 – Orange Partnership for Alcohol and Drug Free Youth Community Coalition Meeting
- May 17, 2018 – Attended Monthly Health Director's Meeting in Raleigh, NC

Program Updates

HPES

- May 8, 2018 – Family Success Alliance received notification of Kenan Charitable Trust Grant Award of $300,000 over the next 3 years for expansion and enhancement of the Navigator Program.
- Healthy Carolinians Coordinator (Ashley Rawlinson) traveled to Person County to facilitate Poverty Simulation Exercise for community partners. Person County expressed their thanks and thought the exercise was a valuable experience and Ashley's facilitation was great!
- Donna King will participate in the SKIP Injury Prevention Process with UNC; there is a focus on gun violence.

PHS

- Inaugural Local Re-Entry Council Meeting held April 27, 2018 was well attended by partners from across the State. Iulia Vann and Tommie Green have implemented the FIT Program with a great start. The program received major compliments during the Re-Entry Council Meeting.
- New STD Express Clinic is going well; this state program allows asymptomatic patients to be fast tracked for services without waiting to see a provider if it's not necessary.

Environmental Health

- Search continues for an EH Director.
- Central Permitting System scheduled to 'Go Live' in early October 2018.

FAS

- Informatics Manager, Allison Young last day is June 29, 2018.
- Received Medicaid Cost Settlement Payment for FY 2016 for ~$800,000.

Upcoming Events

- May 23, 2018 – WUHP interview with Animal Services on rabies.
- June 8, 2018 - Working with our "Buddy" Department, Social Services to plan a joint Management Team Meeting; goal is to enhance department and staff relationships across the two departments. First meeting will focus on program overviews and department structure.
- June 22, 2018 – ALL STAFF Department Meeting; staff will view the film. RESILIENCE: The Biology of Stress & The Science of Hope - a critically acclaimed documentary chronicling a new movement among pediatricians, therapists, educators and communities, who are using cutting-edge brain science to disrupt cycles of violence, addiction and disease.

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THE NEWS of ORANGE COUNTY

Orange County Children receive support from the Family Success Alliance

Story

Print Font Size:

Submitted Photo

Family Success Alliance navigator

Family Success Alliance navigator Claudia Yerena, on the left, stands with a family that has been helped by the organization.

Posted: Thursday, May 10, 2018 11:44 am

By Elijah Larson, News of Orange Editorial Assistant

Orange County is number one in the state for income disparity and around 30 percent of its residents earn below a living wage, recent studies of poverty in the state have shown. The Hillsborough-based Family Success Alliance is trying to change this.

The organization, which began its work in 2015, focuses on the most impoverished areas of the county, helping families with children in school to gain opportunities that can help bring their children out of poverty.

Operating through the Orange County Board of Health, FSA was created to be based off the Harlem Children's Zone, a similar organization created in 1970 in New York. FSA employs navigators, county residents with experience working with impoverished children, who are assigned to one of two zones that the FSA works in.

Navigators meet with families that are a part of FSA to discuss what support the families need and how they can achieve it. This process is called motivational interviewing, where navigators sit down with the families and find out what they need for their children. The goal is to be able to get past everyday emergencies and to look towards aspirational goals of the future, like securing better housing, a GED to acquire a better job, or enrichment opportunities for their children,

"Sometimes when you're in the thick of crisis it's hard to look at a bigger goal," explains Kristin Prelipp, communications manager at FSA. "But that bigger goal is something that can get you out of this."

Family Success Alliance is also partnered with many other organizations, such as county wide literacy programs, UNC health care, and many different educational opportunities for children like HeadStart and Kidscope.

After meeting with navigators, families are then assigned to some of these programs, depending on the goals that they've made, and what FSA thinks they need to be able to succeed.

Prelipp continues to add that, “we have our own goals, to work with a family from birth to graduating high school and further, making a seamless pipeline of services from prenatal all the way up to career.”

“We live in our own little bubble.” Prelipp explains. “We’re becoming a county of the haves and have-nots, and I want people to be aware of that, because who wants to live in a place where people are really struggling?”

Family Success Alliance isn’t just work to change this, they’re getting results. Nearly 90 percent of their enrolled families have stated that their child have been performing better in school since joining FSA, and half of the families polled in a survey put out by FSA reported that their housing situation has improved.

More information about FSA, how it works, how to volunteer, or how to look into signing up for programs, can be found on their website.

Print

Posted in Education on *Thursday, May 10, 2018 11:44 am.*

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Orange County Health Department Confirms 2 Related Whooping Cough Cases

Posted by Blake Hodge | May 7, 2018 | Health | 0

ORANGE COUNTY HEALTH DEPARTMENT
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A case of whooping cough prompted a cautionary message to parents of students at one Orange County elementary school.

The letter from Orange County Health director Quintana Stewart was sent to parents of students at Grady Brown Elementary School in Hillsborough late last week. Stewart wrote that the department "has identified one confirmed case of Pertussis" at the school.

Orange County Health Department spokesperson Kristin Prelipp told WCHL that two cases of whooping cough were confirmed in a nine-year-old student at Grady Brown Elementary and their nine-month-old sibling.

Both children were vaccinated, according to Prelipp. The letter sent to parents said that the vaccinations are effective in "preventing disease in 80%-85% of those who are vaccinated."

This letter comes after a whooping cough outbreak earlier this year. There were 20 cases of Pertussis during that outbreak, according to an email from Stewart to other officials.

An outbreak is defined as being three or more unrelated cases of whooping cough.

The Centers for Disease Control and Prevention says that whooping cough "usually starts with cold-like symptoms and maybe a mild cough or fever."

As the disease progresses, symptoms evolve to fits of rapid coughs, vomiting and exhaustion.

While both children affected by whooping cough in this scenario were vaccinated, the CDC maintains the Pertussis vaccine is beneficial and important to prevention.

Related

Whooping Cough Outbreak at Two Chapel Hill High Schools
Whooping Cough Confirmed in Hillsborough
Young Children At High Risk Of Whooping Cough

The Courier-Times
Your Connection to Roxboro and Person County!

2018-05-02 / Front Page

Simulation imitates poverty

By Anna Fletcher
Courier-Times Staff Writer
annafletcher@roxboro-courier.com

Participants consider how to best use their identities' limited means at a Community Action Poverty Simulation Exercise, held in the Southern Human Services Center in Chapel Hill on Feb. 9. *submitted*

Think you know what it's like to be poor? You might want to think again.

The Person County Health Department is challenging residents to "rethink poverty" through a free Community Action Poverty Simulation Exercise on Friday, May 11 from 1-4 p.m. in the FEMA/ multipurpose room of the Person County Human Services building.

The simulation is an interactive, immersive experience that sensitizes community participants to the realities of poverty. Participants role-play a month in poverty to experience the lives of low-income families before learning about and brainstorming ways to bring about community change.

Poverty is a grow ing concern

According to a 2016 U.S. Census survey, 18.5 percent of Person County residents and 13.8 percent of families earn an income that is below the poverty level. Single mothers with children under the age of five make up the

largest percentage of local families living below poverty, at 69.8 percent, the census says.

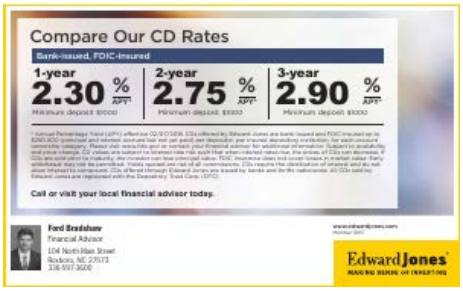
A community health survey done every few years by the Person County Health Department and the Healthy Personians organization shows that poverty is not only prevalent in the community, but a growing concern among residents.

In 2011, the survey listed low income and poverty as the fifth-highest community health concern. In 2014, the survey – which reaped responses from 624 residents – listed them as the second-highest concern.

'Better understand different populations'

In the poverty simulation, each participant is assigned the role of a lowincome resident and must use their limited budget to buy services from stations set up along the perimeter of the room, such as banks, schools and grocery stores. The roles range from an elderly person living alone to someone living with a disability to a parent with three young children.

A unique tool used by over 1,000 different organizations worldwide, the simulation is used by nonprofit organizations, schools and community centers to move people to think about the harsh realities of poverty and to discuss how communities can address the problem.



By allowing participants to step into real-life situations of others, it's intended to break down stereotypes and move people to make a difference.

Coupled with the community health survey, the exercise will provide a

learning experience for residents and a way for local departments to address health equity in the county, says PCHD health educator LeighAnn Creson.

"We're looking at trying to better understand different populations in the community that we serve to help us serve them better by helping us see things through where they're coming from," she said.

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Agenda Item Number:

ORANGE COUNTY BOARD OF HEALTH
AGENDA ITEM SUMMARY

Meeting Date: May 23, 2018

Agenda Item Subject: Orange County Schools – Child Nutrition Services

Attachment(s): PPT Presentation

Staff or Board Member Reporting: Valerie Green

Purpose: ____ Action
_X_ Information only
____ Information with possible action

Summary Information:

Child Nutrition Services will be on hand to present information regarding:

- Financials
- Detailed program information
- What they have going on now
- How the Board can be supportive

Recommended Action: ___Approve
___Approve & forward to Board of Commissioners for action
___Approve & forward to _____
_X_Accept as information
___Revise & schedule for future action
___Other (detail):

Orange County Schools

Child Nutrition Services

May 23, 2018

Background Information

Director
Valerie Green

Lead Office Support
Margie Davison

Office Support
Vicki Carden

Background Information

Child Nutrition Management
12 Child Nutrition Managers

Child Nutrition Staffing
48 Child Nutrition Assistants
(Full Time , Part Time and Dual Employees)

Child Nutrition Services Financials

Maintain a non-profit school food service and observe the limitation on food service revenues in 7 CFR 210.14(a)

- The programs offered are for the children
- Funds may be used for program expenses only
- Classified as an Enterprise Account
- Follow appropriate accounting procedures

Child Nutrition Services Financials

Revenues

- Federal Reimbursement for Meals
- A la Carte Sales
- Adult Meal Sales
- Catering
- State Revenue Match Funds
- Interest/Equipment Sales
- Donations, Rebates and Grants

Child Nutrition Services Financials

Expenditures

Child Nutrition Services is expected to operate as revenue producing business . The revenues generated must cover the cost of:

- Food and supplies
- Equipment and technology
- Salaries for all staff
- Benefits (health, longevity, workman's compensation)
- State-mandated pay raises
- Orange County Living Wage Increases
- Indirect costs
- Other departmental expenses

Child Nutrition Services Financials

How Child Nutrition Services Meet their Financial Needs

- Cooperative Purchasing- North Carolina Procurement Alliance
- Controls labor,equipment and food cost
- Share responsibilities with other school departments
- Grants- NCDPI Equipment Grants , Action for Healthy Kids, and others
- Assesses menu costing with new products

Child Nutrition Services Programs

- National School Lunch Program (NSLP)
  - Afterschool Snack Service
- School Breakfast Program (SBP)
- Summer Food Service Program (SFSP)
- Child and Adult Care Food Program (CACFP)
  - At-Risk Afterschool Meals

The Big Picture, How We Work

Evaluate menus include local preferences try new products

↓

Train staff on “new” ideas and preparation

↓

Promote program like other competitive businesses

↓

Monitor student acceptance

↓

Keep it going- get all levels of staff involved-Wellness Committees

↓

Use ready available resources

Child Nutrition Services Programs

National School Lunch Program

- ☐ All 13 of OC schools operate the National School Lunch Program
- ☐ Approximately3115 lunches are served per day
- ☐ Free and Reduced Percentage as of April 30 is____
- ☐ Every lunch must include either a vegetable or fruit serving
- ☐ Meals are served on regular school days

Child Nutrition Services Programs

After School Snack Program

- ☐ 7 Sponsored and operated by Orange County Schools
- ☐ All snacks are served free at area eligible schools (where 50% or more of students qualify for +F/RP meals)
- ☐ Free, reduced price, and paid snacks at all other schools (non-area eligible schools)(Hillsborough Elementary and Cameron Park)
- ☐ Children must be age 18, or under, at start of school year
- ☐ Served on regular school days

Child Nutrition Services Programs

School Breakfast Program

- ☐ Serving breakfast at school helps to ensure that all students have an opportunity to enjoy a morning meal
- ☐ Universal Free Breakfast Program for Prekindergarten – 5th Grade (Elementary Schools only)
- ☐ OCS serve appropriately 1700 breakfast meals collectively
- ☐ No Kid Hungry Breakfast Pop-Ups/Alternative Methods– New Hope Elementary School (Grab &Go) Kiosk, Cameron Park Elementary School(Grab &Go and Breakfast after the bell)and Efland Cheeks Global School (Grab & Go)
- ☐ Action for Healthy Kids Grant ($3000)– New Hope Elementary School to increase breakfast participation by presenting the Voyager Feed Your Brain Kiosk.

Child Nutrition Services Programs

Summer Food Service Program

- Operates during June, July and August each year
- 10 Sites operated in 2017 Summer
  - Breakfast- 6744 meals
  - Lunches-11,113 meals
  - Snacks-211 meals
- 8 Sites will operate in 2018 Summer

Child Nutrition Services Programs

At Risk Afterschool Meals

- ❑ No cost afterschool meals s are offered at sites where 50 percent or more of the students are eligible for free or reduced price meals

- ❑Coming Soon 2018-2019 School Year

What's Cooking…

- Increase participation with the School Breakfast programs by offering a grab and go options in the universal free breakfast programs.
- Continue to offer both hot and cold items in breakfast programs.
- Consider offering a "Second Chance" Breakfast, offer kiosks for grab and go in middle and high schools- make the meal easy accessible

What's Cooking…

- Continue to work jointly with School Health Advisory Council and Health and Physical and Activity Committee of OC Health Department to promote healthy lifestyles at events- such as a health fair and other activities affiliated with Orange County Schools
- Consider to offer additional healthy lunch options for high school and middle schools

What's Cooking…

- Continue developing "kid-friendly" menus that are promoting healthy choices as well as "Home Style" options.
- Continue to work with local government and agencies to procure local growers produce.
- Managers will participate in ongoing CN professional development.
- Managers will continue to perfect their marketing plans for their schools to promote their programs

Getting Involved

- Visit the cafeterias during lunch and breakfast
- Continue to have representation on the School Health Advisory Council to support school activities
- Assist elementary managers and staff with nutrition education projects for their schools
- Assist to create “School Lunch Snapshots” for the morning announcements, parental meetings and school events
- Assist with incorporating cooking techniques or healthy eating topics part of the curriculum along with guidelines for managers and staff

Getting Involved

- Donation assistance
- Provide nutrition educational materials for children
- Assist with décor for middle and high school cafeterias
- Professional development opportunities for managers
- Assist with adding cooking techniques and healthy eating topics to a curriculum that will include guidelines for managers and staff

Agenda Item Number:

ORANGE COUNTY BOARD OF HEALTH
AGENDA ITEM SUMMARY

Meeting Date: May 23, 2018

Agenda Item Subject: Racial Equity Commission Presentation

Attachment(s): PPT Presentation

Staff or Board Member Reporting: Steven Campbell, Beverly Scurry, Kristen Prelipp

Purpose: ____ Action
_X_ Information only
____ Information with possible action

Summary Information:

The Racial Equity Commission formed in 2017 will present to the Board:

- History/Formation
- Charter
- Accomplishments Thus Far
- Equity Summit Video – produced by Kristen Prelipp
- Future Aspirations
- Questions

Recommended Action: ___Approve
___Approve & forward to Board of Commissioners for action
___Approve & forward to _____
_X_Accept as information
___Revise & schedule for future action
___Other (detail):

Established 2017

ORANGE COUNTY
HEALTH DEPARTMENT

HISTORY

- Formation
- Concept

REC FORMATION

- Staff members who attended the Racial Equity Institute (REI) trainings realized that more staff members needed to know about equity, diversity, and inclusion
- OpenSource Leadership Strategies, Inc. was invited to conduct trainings at OCHD in the spring of 2017
- After four sessions with OpenSource, participants were asked "What will you do next?"
- REC – Racial Equity Commission – was the answer

ORANGE COUNTY
HEALTH DEPARTMENT

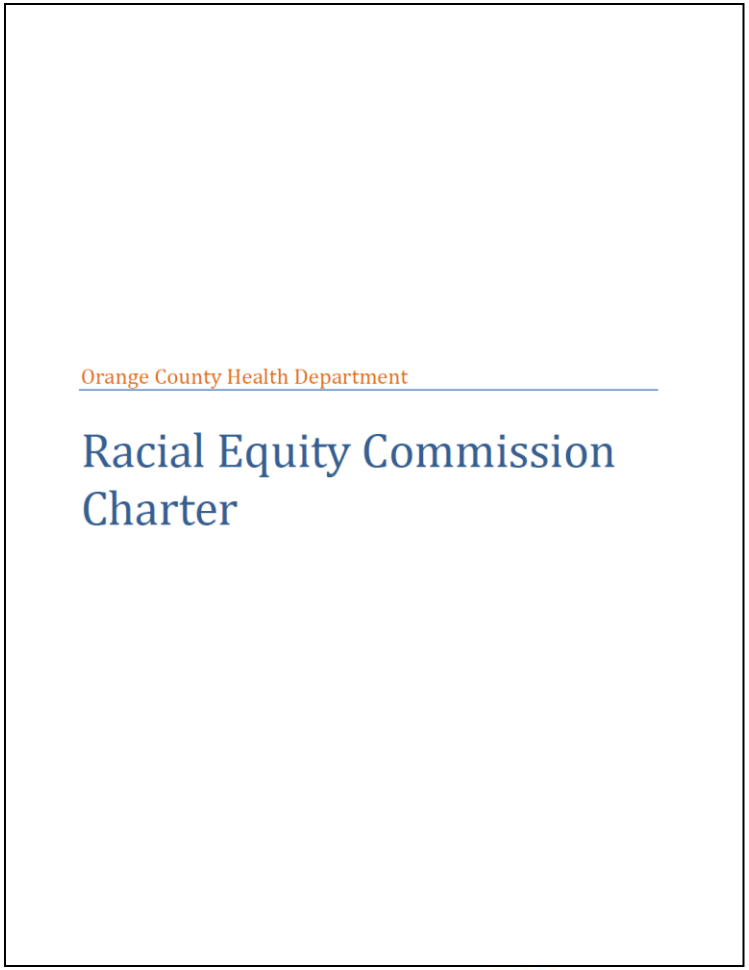
REC CONCEPT

- Led by a group of staff members coming together to be a catalyst for racial equity in OCHD
- To create an environment that allows coworkers to analyze workplace norms, structures, power dynamics, and culture
- To operate from a lens that considers equity, diversity, and inclusion

ORANGE COUNTY
HEALTH DEPARTMENT

REC CHARTER

- In order to ensure that REC is viewed as an official health department entity, a charter was developed, signed, and supportive by both the interim health director, Dorothy Cilenti and the current director, Quintana Stewart.


Orange County Health Department

Racial Equity Commission Charter

ORANGE COUNTY HEALTH DEPARTMENT

REC CHARTER

Vision

The OCHD is an organization where racial equity is a priority and is constantly examined both internally and externally.

Mission

To serve as a catalyst to ensure that racial equity is an active agent throughout all organizational processes of the OCHD

ORANGE COUNTY HEALTH DEPARTMENT

REC CHARTER

Goals:

- Increase participation of staff in racial equity training and conversations
- Create a racially equitable environment within OCHD
- Support and encourage the use of affinity group caucusing
- Cultivate continuous departmental conversations around equity
- Create formalized support systems for those burdened by racism
- Develop racially equitable programs and policies for OCHD's work in the community

ORANGE COUNTY HEALTH DEPARTMENT

REC CHARTER

Membership:

- Each division of the health department will have one member on the commission (5 seats). There are four at-large seats. Making a total of 9 members.
- We will always strive to have diversity in our membership.
- All members are required to attend a racial equity training, preferably given by the Racial Equity Institute or any training that is deemed as an equivalent.
- Members will serve no more than 2 consecutive two year terms. After sitting out a term they may return to the commission when availability permits.
- New members are welcome on a first come basis, provided they meet criteria.
- However in order to keep diversity on the team, there may be times that membership will only be open to certain affinity groups.

ORANGE COUNTY
HEALTH DEPARTMENT

ACCOMPLISHMENTS

- Diversity Policy
- Staff Training
- Newsletters
- Summit

Angela Glover, CEO, PolicyLink & John Powell, Director, Haas Insitute

Photo Credit: Christopher Moore, www.christophermooremedia.com

ORANGE COUNTY HEALTH DEPARTMENT

INCLUSIONARY PRACTICES POLICY

- Diversity Policy → Inclusionary Practices Policy
- Raises awareness by using language such as:
  - racial equity
  - health equity
  - cultural humility
- Creates intentionality with language such as:
  - Require completion of a least one training
  - Staff should provide proof of training on their WPPR
  - Encourage the use of caucusing
  - Ensure that leadership and management is reflective of the diversity of the population

ORANGE COUNTY HEALTH DEPARTMENT

STAFF TRAINING

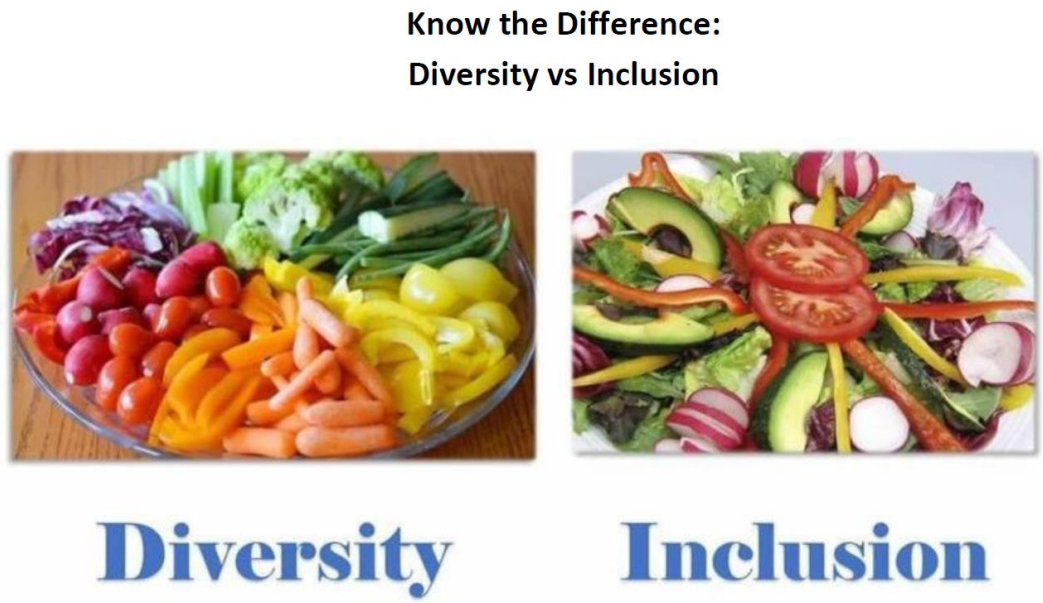
- Racial Equity Institute
  - Groundwater
  - Phase I
  - Phase II
  - Latinx Challenges for Racial Equity
- OpenSource

57% of staff have attended one or more of the above trainings

ORANGE COUNTY HEALTH DEPARTMENT

NEWSLETTER

- Data Collection
- Definitions
- Information
- Training
- Resources



ORANGE COUNTY
HEALTH DEPARTMENT

EQUITY SUMMIT 2018

- Orange County Delegation
- Pre & Post Convening
- Next Steps

Angela Glover, CEO, PolicyLink & Mitch Landrieu, Mayor, City of New Orleans
Photo Credit: Christopher Moore, www.christophermooremedia.com

ORANGE COUNTY HEALTH DEPARTMENT

FUTURE ASPIRATIONS

- Strategic Planning
- Internal to External Focus
- Policies
- GARE

ORANGE COUNTY
HEALTH DEPARTMENT

STRATEGIC PLANNING

- OpenSource Leadership Strategies, Inc.
- Strategic Planning from

  May 2018 – November 2018
- BOH Support

Racial Equity
Strategic Planning Team

Steven Campbell
Beverly Scurry
April Richard
Tommy Green
Meredith McMonigle
Kristen Prelipp
Susan Clifford
Mike DeFranco
Roberto Diaz
Ruth Cisneros
Evy Rojas
Ana Salas

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INTERNAL TO EXTERNAL FOCUS

- Work environment/culture
- Programming/services
- Reputation/how the community views us

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POLICIES

- Hiring
- Leadership
- Racially equitable policies

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GARE

LOCAL AND REGIONAL
GOVERNMENT ALLIANCE ON
RACE & EQUITY

- Government Alliance on Race & Equity
- A Merging of Race Forward and CSI (Center for Social Inclusion)
- A national network of government working to achieve racial equity and advance opportunities for all.
- Have 80+ member jurisdictions since they formed in 2015.

ORANGE COUNTY
HEALTH DEPARTMENT

WRAP UP

- County Government on board
- Encourage BOH members to attend REI
- Encourage BOH members to support REC
- Questions

ORANGE COUNTY
HEALTH DEPARTMENT

CURRENT MEMBERS

Steven Campbell – Chair

Beverly Scurry – Co-Chair

April Richard

Ashley Rawlinson

Meredith McMonigle

Allison Young

Dr. Stephanie George

Cheryl Bono-Zehia

Susan Clifford

ORANGE COUNTY
HEALTH DEPARTMENT

Agenda Item Number:

ORANGE COUNTY BOARD OF HEALTH
AGENDA ITEM SUMMARY

Meeting Date: May 23, 2018

Agenda Item Subject: Board of Health Strategic Plan 2018-2020

Attachment(s): Strategic Plan 2018-2020

Staff or Board Member Reporting: Beverly Scurry

Purpose: ____ Action
_X_ Information only
____ Information with possible action

Summary Information:

Beverly will share a comprehensive summary of the BOH Strategic Plan updates and revisions noted as a result of the 3 subcommittee meetings with Board members. Collectively, BOH members will have an opportunity to give feedback in preparation of the final document.

Recommended Action: ___Approve
___Approve & forward to Board of Commissioners for action
___Approve & forward to _____
_X_Accept as information
___Revise & schedule for future action
___Other (detail):

Orange County Board of Health

Strategic Plan 2018-2020

Well-child exams | Disease Screening | Immunizations | Family Planning

Primary Care Services | Maternal Health | Nutrition Counseling | Smoking Cessation

Dental Exams & Cleaning | Fillings & Extractions | Sealants | Infant Oral Care

Need to include inclusive words of all divisions

DRAFT

ORANGE COUNTY
HEALTH DEPARTMENT

Improving health. Inspiring change.

Medical Clinics in Chapel Hill & Hillsborough - Pediatric & Adult Dental Clinic in Hillsborough

(919) 245-2400 **www.OrangeCountyNC.gov/Health**

Orange County
Board of Health Strategic Plan 2018-2020

Charge

The Board of Health is the primary policy-making and adjudicatory body for the Health Department. It is charged to protect and promote the public health of Orange County. Every two years, the Board of Health establishes a new strategic plan based on community health priorities and research on policies proven to improve community and individual health.

Contents

Introduction **Pgs. 1-4**

Priority: *Social Determinants of Health* **Pg. 5**

Focus Area #1: Serve as a catalyst and advocate for health outcomes in the Family Success Alliance.

Focus Area #2: Advocate for and pursue policies and practices aimed at improving access to care, with a focus on cultural and language barriers to access.

Priority: *Physical Activity & Nutrition* **Pg. 6**

Focus Area #1: Advocate for and pursue policies, practices, and partnerships aimed at increasing access to healthy foods and safe places for physical activity.

Focus Area #2: Advocate for and pursue evidence-based policies, practices, and partnerships that increase physical activity and improve nutrition in schools.

Priority: *Substance Abuse & Mental Health* **Pgs. 7-8**

Focus Area #1: Serve as a catalyst and advocate for policies and practices that promote integrated care in the Orange County Health Department and other medical providers in the county.

Focus Area #2: Advocate for and pursue policies, practices, and partnerships that improve substance abuse and mental health services in Orange County, especially to vulnerable populations such as the homeless and those connected with the criminal justice system.

Engagement **Pg. 8**

Focus Area #1: Actively engage with local government, advisory boards, and the community on Board of Health strategic plan priority areas.

Timeline **Pg. 9**

DRAFT

Introduction

Every four years the Orange County Board of Health commissions a Community Health Assessment (CHA) to identify pressing and emerging community health issues. The latest Community Health Assessment was completed in December of 2015. As in years past, the Board adopted the community's top three health priorities from the CHA to focus the Board's next policy-focused Strategic Plan.

The three priorities: *1) Social Determinants of Health*; *2) Physical Activity & Nutrition* and *3) Substance Abuse & Mental Health* were the community's top three health priorities. More detailed information on the most recent CHA is available on the Health Department website here.

To oversee the work of the Strategic Plan, the Board of Health has three oversight committees—one for each priority—that meets to ensure action steps and deliverables are met.

2016—2018 Strategic Plan Highlights

Full report accessible on Board of Health website

Social Determinants

- The Orange County Dental Clinic implemented a text messaging service in 2017. Since implementation there have been 2000 confirmed appointments, 2394 email addresses have been enabled and confirmed valid, 7800 cell phones (text) have been enabled and confirmed valid, and the patient no show rate has decreased from 15% to 12% since implementation
- The Board of Health received a report, found here, on Over-the-Counter Birth Control.

Physical Activity and Nutrition

- The BOH supported three teachers of the Partnership Academy in the Orange County School System to attend the Action-Based Learning Training to implement physical activity in the classroom.

Substance Abuse & Mental Health

- Integrated Behavioral Health Report
- Cardinal Annual Report
- The Orange County Health Department has a designated seat on the Orange County Justice Advisory Council (JAC). The JAC's goals include examining the County's justice system through collaborative efforts and research, promoting safety, improving the just and efficient treatment of offenders and reducing crime rates, incarceration rates and recidivism.

Engagement

- Twice a year the board is presented with a summary report of local boards within Orange County. The report is based on the work of local boards as it pertains to the top priorities of the Board of Health.

DRAFT

Strategic Planning in Context

The Board of Health Strategic plan is situated in a broader context of purposeful planning and actions that provide the Board, Health Department staff, and the Orange County community with a clear picture of local health goals, plans and strategies to achieve these goals, and the measures used to monitor progress. These plans not only communicate how we will address the community's health priorities, but also how our values as an organization drive our work.

The Orange County Health Department (OCHD) has undergone a major leadership change. In December 2017, the new Health Director, Quintana Stewart, MPA was hired to lead the organization forward and guide the board in a strategic direction of innovation and accreditation accountability.

OCDH will undergo a new Community Health Assessment (CHA) process in 2019 and Accreditation process in 2021. These processes greatly inform the strategic direction and leadership of the Board of Health. Closely aligning the Boards strategic plan with the CHA and Accreditation processes will allow the board to implement policies, recommendations, and guidelines that align with the state mandated responsibilities of the department and needs of the greater community.

The innovative work within the OCHD does not stop at strategic processes. The department is dedicated to looking at those processes with a racial equity lens. OCHD recognizes that systems can be responsible for perpetuating racism in the community. OCHD is working to dismantle racism by examining policies, programs, and services to ensure that all clients receive the services that they need most.

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Priority: Social Determinants of Health

Health is much more than what happens within the walls of a clinic or hospital. Health is influenced by our homes, schools, jobs, and access to social and economic opportunities. These impacts on health are known as the Social Determinants of Health (SDH). Issues such as poverty, access to care, employment and transportation were all discussed as important SDH in Orange County by residents during the 2015 Community Health Assessment. The Board of Health will work to address these issues through two focus areas:

1) Serve as a catalyst and advocate for health outcomes in the Family Success Alliance.
2) Advocate for and pursue policies and practices aimed at improving access to care, with a focus on cultural and language barriers to access.

Action Steps

Focus Area #1 – Serve as a catalyst and advocate for health outcomes in the Family Success Alliance

1) By December 2018, Health Department staff will explore the use of clinical tools, such as ACEs screening, to use in OCHD clinics to identify important social determinants of health and appropriate interventions.
2) By November 2018, the Board of Health will further explore policy and funding options to support the newly created Family Success Alliance Strategic Plan.

Focus Area #2 – Advocate for and pursue policies and practices aimed at improving access to care.

1) By December 2019, the Board of Health will offer support to the Healthy Carolinians Access to Care Committee on Transportation and 211 options in the Orange County community.

DRAFT

Priority: Physical Activity and Nutrition

Obesity remains a top health concern for Orange County adults and children. Chronic diseases are the leading cause of death in Orange County, and heavily influenced by physical activity and nutrition. Prevention is the most effective way to address obesity and the chronic diseases related to it. Effective prevention means ensuring safe places for physical activity and access to healthy foods in all communities. The Board of Health will work to address these issues through two focus areas:

1) Advocate for and pursue policies, practices, and partnerships aimed at increasing access to healthy foods and safe places for physical activity.
2) Advocate for and pursue evidence-based policies, practices, and partnerships that increase physical activity and improve nutrition in schools.

Action Steps

Focus Area #1 – Advocate for and pursue policies, practices, and partnerships aimed at increasing access to healthy foods and safe places for physical activity.

1) By September 2018, the BOH will collaborate with the Orange County Food Council and UNC Students to explore food policies that are feasible to implement in the Orange County community.
2) By June 2019, the PAN Subcommittee will explore the creation of a health app, to highlight safe places for physical activity and nutrition options in Orange County.

Focus Area #2 – Advocate for and pursue evidence-based policies, practices, and partnerships that increase physical activity and improve nutrition in schools.

1) Each fiscal year for the school systems in Orange County, the Board of Health will offer a formalized small grant opportunity to all schools to implement in-class or other physical activity programs.

DRAFT

Priority: Substance Abuse & Mental Health

Substance abuse and mental health issues permeate local public health. From exposure to environmental tobacco smoke causing an increase in cardiovascular disease to the challenges associated with ensuring medication compliance in a depressed patient with a communicable disease, mental health and substance abuse have far-reaching health and economic impacts. Addressing these problems will take a fully engaged and active presence by all organizations serving these clients. The Board of Health will address this issue through two focus areas:

1) Serve as a catalyst and advocate for policies and practices that promote integrated care in the Orange County Health Department and other medical providers in the county.
2) Advocate for and pursue policies, practices, and partnerships that improve substance abuse and mental health services in Orange County, especially to vulnerable populations such as the homeless and those connected with the criminal justice system.

Action Steps

Focus Area #1: Serve as a catalyst and advocate for policies and practices that promote integrated care in the Orange County Health Department and other medical providers in the county.

1) By March 2019, Health Department staff will investigate the feasibility, follow-up referral options, and reimbursement barriers for primary care providers to provide and bill for Screening, Brief Intervention, and Referral to Treatment (SBIRT), telephone and face-to-face consultation with behavioral health providers, and care provided by a behavioral health and primary care provider on the same day in the same clinic.

Focus Area #2: Advocate for and pursue policies, practices, and partnerships that improve substance abuse and mental health services in Orange County, especially to vulnerable populations such as the homeless and those connected with the criminal justice system.

1) By June 2019, the SAMH Subcommittee will explore with Cardinal Innovations Healthcare Solutions and other local mental health stakeholders the evidence-base, feasibility of, and follow-up referral options for mental health screening and referral kiosks in target community locations.
2) By June 2019, Health Department staff will partner with criminal justice and jail partners to explore a pilot system to ensure continuity of behavioral health care during and after incarceration.

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Engagement

The Board of Health plays a key role in advocating for policies and activities that positively impact the health of Orange County residents. As a part of building an active culture of health within our county, the Board aims to have engagement with and from the community at large. The Board of Health will work to address this issue through one primary focus areas:

1) Engaging with local government, advisory boards, and the community on Board of Health strategic plan priority areas

Action Steps

Focus Area #1: Actively engage with local government, advisory boards, and the community on Board of Health strategic plan priority areas.

1) The Board will receive summaries on the activities of applicable local boards or governing bodies at meetings two times per year, or as necessary for timely board action.
2) The Board will support racial equity work in the Orange County community by collaborating with and establishing partnerships with local community partners who are also working on racial equity within their organization and community.

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