

Chapter 38

Public Health

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In 1988, The Institute of Medicine defined public health as “what we, as a society, do collectively to ensure the conditions in which people can be healthy.”¹ The emphasis this definition places on collective action and the conditions that promote good health reflects a distinction between public health and medicine: public health is concerned with the health of populations, not just the health status or condition of particular individuals.

The oldest and most traditional concerns of public health systems—sanitation and disease control—reflect this focus. Practices such as isolation of the ill and proper food handling are described in the Old Testament book of Leviticus, a book that is viewed by public health scholars as the first written public health code. The focus on collective action and population-based activities is also the reason public health has long been a function of government.

In North Carolina, state law has provided the authority and defined the infrastructure for governmental public health since the early eighteenth century, when the territory that is now North Carolina enacted a maritime quarantine law. Today, a full chapter of the North Carolina General Statutes (hereinafter *G.S.*), Chapter 130A, is devoted to the laws that address the authority and roles of the state and local agencies that constitute North Carolina’s public health system and prescribe many of the methods and programs through which public health activities are carried out.

Today, the public health system continues to carry out the traditional functions of ensuring sanitation and controlling infectious diseases, but its focus has expanded to include other duties and embrace other roles. Among other things, the public health system today systematically monitors the health status of the state’s residents, serves as a

1. Institute of Medicine, *The Future of Public Health* (Washington, D.C.: National Academy Press, 1988), at 1. The Institute of Medicine expressed its continued support for this definition in its 2002 report, *The Future of the Public’s Health in the 21st Century* (Washington, D.C.: National Academy Press, 2002), at 28.

provider of health care services, and engages in a number of community-based activities designed to promote health and prevent chronic disease or injury.

Responsibility for Public Health in North Carolina

The General Assembly has declared that the purpose of the state's public health system is "to ensure that all citizens in the State have equal access to essential public health services," and the system's mission is to promote and contribute to the highest level of health possible for the people of North Carolina by

- identifying and preventing or reducing community health risks;
- detecting, investigating, and preventing the spread of disease;
- promoting healthy lifestyles and a safe and healthful environment;
- promoting the accessibility and availability of quality health care services in the private sector; and
- providing health care services when they are not otherwise available.²

In order to satisfy this mission and purpose, the law assigns to local health departments the responsibility for ensuring that ten essential public health services are available and accessible to the residents of each county served by the department.³

North Carolina thus has a decentralized public health system, in which the state and county governments share legal authority to act to protect and promote public health as well as the responsibility for assuring that public health services are available to all of the state's residents. However, most public health service delivery occurs at the local level, through various forms of local health departments.⁴

Public Health at the State Level

Statewide public health activities and programs are carried out by officials and agencies within the North Carolina Department of Health and Human Services (DHHS). The officials with primary responsibility for public health are the secretary of DHHS and the state health director. The principal agencies are the Commission for Public Health, the Division of Public Health (within DHHS), and the North Carolina Local Health Department Accreditation Board. Together, these individuals and agencies

- make and enforce statewide rules for public health programs,
- administer statewide public health programs and provide some direct services,
- oversee and provide technical assistance for local public health programs,
- distribute federal and state funds to local public health agencies,
- assure that local public health agencies meet state law requirements for accreditation, and
- coordinate North Carolina's public health activities with other state and federal agencies.

State Officials: Secretary of Health and Human Services, State Health Director

The North Carolina Secretary of Health and Human Services is appointed by the governor and oversees all the department's activities.⁵ A state statute gives the general responsibility for administering and enforcing most of the state's

2. N.C. Gen. Stat. (hereinafter G.S.) § 130A-1.1.

3. *Id.* The ten essential public health services are described later in this chapter in the section on local public health services.

4. The term *local health department* encompasses county health departments, district health departments, public health authorities, and the public health components of consolidated human services agencies. See G.S. 130A-2(5); 130A-43.

5. At this writing, DHHS has thirty divisions and offices, including early childhood programs; services for the deaf and blind; aging services; health care facilities regulation; public health, social services, and mental health; developmental disabilities; and substance abuse services. The department is also responsible for fourteen state facilities, including psychiatric hospitals, substance abuse treatment centers, and developmental centers for individuals with developmental disabilities.

public health laws to the secretary of DHHS,⁶ but in practice many duties are carried out by the state health director, who is appointed by the secretary.⁷ In addition, a few state laws give powers and duties directly to the state health director. For example, the communicable disease laws give the director the power to issue temporary orders requiring health care providers to report certain health conditions,⁸ the authority to inspect medical records in an outbreak,⁹ and the authority to impose isolation or quarantine.¹⁰

Commission for Public Health

The Commission for Public Health is the primary rulemaking body for public health in North Carolina. A state statute gives the commission the general authority to adopt rules to protect and promote the public health, including rules that are necessary to implement statewide public health programs.¹¹ In addition, numerous provisions throughout G.S. Chapter 130A direct the commission to adopt rules regarding specific public health activities or programs, ranging from communicable disease control, to the inspection and grading of restaurants, to the decontamination of properties used for the manufacture of methamphetamine.¹² It also has the authority to create metropolitan water districts, sanitary districts, and mosquito control districts. The commission's rules are codified in the North Carolina Administrative Code.¹³

The commission has thirteen members, four of whom are elected by the North Carolina Medical Society. The remaining nine are appointed by the governor and must include a pharmacist, a soil scientist or engineer experienced in sanitary engineering, a veterinarian, an optometrist, a dentist, and a registered nurse. The members serve four-year, staggered terms.

Division of Public Health

The Division of Public Health (DPH) is the agency with primary responsibility for carrying out the public health system's statutory mission: "to promote and contribute to the highest level of health possible for the people of North Carolina."¹⁴ DPH is divided into sections and offices that are responsible for a wide variety of public health services and programs, including chronic disease and injury prevention, environmental health, minority health and health disparities, and

6. G.S. 130A-4(a). The secretary of Environment and Natural Resources has responsibility for administering public health laws related to solid waste management and the N.C. Drinking Water Act. G.S. 130A-4(c).

7. G.S. 130A-3.

8. G.S. 130A-141.1.

9. G.S. 130A-144(b).

10. G.S. 130A-145. Local health directors have some of the same powers and duties as the state health director. For example, local health directors may exercise many of the state health director's communicable disease powers, including the authority to order isolation or quarantine. G.S. 130A-145(a). But some powers are given to the state health director alone. For example, the public health bioterrorism laws authorize the state health director to close property or to order examinations of individuals during a suspected bioterrorism event. G.S. 130A-475(a). Local health directors do not share that authority.

11. G.S. 130A-29.

12. See, e.g., G.S. 130A-144 (communicable disease control); 130A-248 (sanitation of food and lodging establishments); 130A-284 (decontamination standards for methamphetamine sites). These are examples only and not a complete list of statutes authorizing the commission to adopt rules. The N.C. Environmental Management Commission also has some rulemaking authority in the area of public health. It makes statewide rules regarding water sources, including rules governing local health departments' inspection and permitting of private drinking water wells. G.S. 87-97; see also G.S. 143B-282 (creating the Environmental Management Commission and setting forth its rulemaking authority).

13. The rules for environmental health programs are in Title 15A, Chapter 18, of the North Carolina Administrative Code (hereinafter N.C.A.C.). The rules for all other public health programs are in Title 10A, Chapters 39–48.

14. G.S. 130A-1.1. There are other divisions within DHHS that are relevant to the provision of public health services in North Carolina. These include the Office of Rural Health and Community Care, which operates low-cost rural health centers and places health care providers in underserved communities; the Division of Medical Assistance, which administers the Medicaid program; the Division of Health Service Regulation, which is responsible for licensure and certification of health care facilities; and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The mental health, developmental disabilities, and substance abuse services system is described in Chapter 40.

women's and children's health.¹⁵ It also operates several statewide public health programs, including the medical examiner program that conducts postmortem investigations, the state laboratory for public health, the state vital records program, and the state center for health statistics.

The Division of Public Health has general responsibility for oversight of local health department programs. It monitors local services, conducts periodic reviews of local health departments, and assists local health departments by providing training and technical assistance and conducting quality assurance activities. It also ensures local compliance with state public health program standards through its process for distributing state and federal funds to local agencies. DHHS receives federal and state money for public health programs and determines local public health agencies' allocations. To receive certain funds, the local health department must enter into a contract with DHHS, called the *consolidated agreement*.¹⁶ The consolidated agreement requires local public health agencies to comply with all public health laws and rules and specifies how funds must be managed. This contract has a significant effect on how local public health agencies operate, because noncompliance with its terms can result in loss of state and federal funds. It is renewed annually.

Both the state and local public health officials have the authority to enforce public health laws and rules, but most of the enforcement is carried out by the directors and employees of local health departments. State agencies monitor these local enforcement activities and have the authority to intervene if they determine that it is necessary.

DPH maintains relationships and coordinates its work with federal public health agencies, including the Centers for Disease Control and Prevention (CDC). It also works with other state agencies that have responsibilities relating to public health. The North Carolina Department of Agriculture operates the Grade A milk sanitation program and the sleep products sanitation program,¹⁷ and it shares responsibility with public health for the safety of some foods that are served to the public for pay. It also monitors certain diseases in livestock animals, including some diseases that could spread to humans. The state Department of Environment and Natural Resources' responsibilities include the sanitation of public water supplies, shellfish sanitation, and recreational water quality. The Department of Labor is responsible for occupational health and safety. The North Carolina Department of Public Safety leads the state's emergency management operations, including response to natural disasters and other events that affect the public health.

North Carolina Local Health Department Accreditation Board

Every agency functioning as a local health department in North Carolina must obtain and maintain accreditation from the North Carolina Local Health Department Accreditation Board.¹⁸ The board is responsible for developing a schedule by which local health departments must apply for accreditation, reviewing each department's application for accreditation, and assigning an accreditation status as follows:

- *Accredited* means that the department has satisfied the standards for accreditation. Accreditation expires after four years and the department must apply for re-accreditation.

15. At present, the Division of Public Health is composed of eleven sections and offices. See <http://publichealth.nc.gov/aboutus.htm>.

16. The contract is signed by the local health director, the finance director, and, in county health departments, the chair of the board of county commissioners. The chair's signature is required by DHHS; although the health director has authority to enter contracts on behalf of the department, that contracting authority may not be construed to abrogate the authority of the county commissioners (G.S. 130A-41(13)). In district health departments and public health authorities, only the health director and finance director sign the contract.

17. The Grade A milk sanitation program and the sleep products program were transferred from the N.C. Department of Environment and Natural Resources (DENR) to the Department of Agriculture in 2011. S.L. 2011-145. This legislation eliminated the Division of Environmental Health within DENR. Many of the Division of Environmental Health's programs were transferred to the Division of Public Health, but others were transferred to other agencies or abolished.

18. G.S. 130A-34.1. The statutory definition of "local health department" includes a county health department, a district health department, or a public health authority. G.S. 130A-2(5). Although the definition does not mention consolidated human services agencies that include public health, a separate law states that such agencies "shall have the responsibility to carry out the duties of a local health department." G.S. 130A-43(a). Obtaining and maintaining accreditation is one such duty.

- *Conditionally accredited* means that the department has failed to meet the standards for accreditation but has been granted short-term accreditation status that is subject to conditions set by the board. This status is good for two years. By the end of that time, the department must have satisfied the board's conditions and met the criteria for accreditation, or it will become unaccredited.
- *Unaccredited* means that the department has continued to fail to meet the standards after a period of conditional accreditation.

The Commission for Public Health adopts rules and standards for the accreditation process that provide for local health department self-assessments, site visits by the accreditation board, and informal review of board decisions.¹⁹ Effective July 1, 2014, local public health agencies must be accredited by the North Carolina board in order to continue to receive state and federal funding.²⁰

When the local health department accreditation requirement was initially imposed, state appropriations provided the funds for the accreditation board to carry out its activities. Those funds were reduced in 2010 and 2011 and completely eliminated in 2012.²¹ At present, the program continues to operate through a contract with the North Carolina Association of Local Health Directors. Local health departments voluntarily contribute to the association to pay the cost of the contract.

The accreditation board is composed of seventeen members appointed by the secretary of Health and Human Services. The membership includes representatives of boards of county commissioners, local boards of health, local health directors, and staff members of the state divisions of public and environmental health.

Public Health at the Regional Level

North Carolina law does not contain a formal regional structure for public health services. However, in practice, there are several regional entities that carry out either state or local public health responsibilities.

The state public health agencies hire employees, usually called consultants, who are assigned to serve local health departments in designated regions. Consultants work in different disciplines or service areas. For example, there are administrative consultants, nurse consultants working in areas such as child health or school health, and regional environmental health specialists.

The state is divided into four regions for purposes of public health preparedness and response.²² Each region has a field office and staff, including planning consultants, training facilitators, industrial hygienists, pharmacists, and program support specialists. Regional staff members are employed by the state and work with local public health officials. Regional public health preparedness and response staff monitor public health conditions in the regions they serve. They are also responsible for a number of public health preparedness activities, including training the public health workforce and developing public health emergency response plans in collaboration with local and regional entities that work with emergency response or disaster management. Finally, many local health departments participate voluntarily in regional partnerships called *public health incubator collaboratives*—voluntary collaborations designed to “hatch”

19. The rules are codified in Chapter 48 of Title 10A of the North Carolina Administrative Code.

20. G.S. 130A-34.4.

21. The legislative conference committee report on the 2012 state budget included the reduction and noted that there is a national program that accredits local health departments. North Carolina General Assembly, The Joint Conference Committee Report on the Continuation, Expansion, and Capital Budgets (corrected version, Aug. 31, 2012), at G-9, www.ncleg.net/sessions/2011/budget/2012/Revised_Joint_Conference_Committee_Report_2012_08_31.pdf. The national Public Health Accreditation Board (PHAB) is a voluntary program that local health departments may participate in if they choose; however, state law requires North Carolina local health departments to be accredited through the North Carolina-specific program. G.S. 130A-34.1 (creating the North Carolina program and requiring local health departments to obtain and maintain accreditation through it); 130A-34.4 (requiring health departments to obtain and maintain state accreditation as a condition of receiving state and federal funds, effective July 1, 2014).

22. The public health preparedness and response (PHP&R) teams replaced the seven public health regional surveillance teams (PHRSTs) that were described in the 2007 version of this chapter. A map showing the counties served by each PHP&R team is available at <http://epi.publichealth.nc.gov/phpr/regions.html>.

new ideas and practices to improve public health. Participation in incubator collaboratives is voluntary, and the incubators themselves do not have specific duties or authorities under North Carolina’s public health laws.²³

Public Health at the Local Level

Local Health Departments

Each county in North Carolina is required by law to provide public health services.²⁴ A county may satisfy this duty by operating a county health department, participating in a multi-county district health department, forming or joining a public health authority, establishing a consolidated human services agency that includes public health, or contracting with the state to provide public health services. Each type of agency is captured in the generic term *local health department*.²⁵ Each type of agency has a governing board, which may be called a *board of health*, a *public health authority board*, or a *consolidated human services board*. For purposes of this chapter, the term *board of health* is used to refer to all of those.²⁶ A board of health may be an independent board appointed by the county commissioners, or the commissioners may elect to serve as the board of health themselves by adopting a resolution abolishing the board and conferring its powers and duties upon the board of commissioners.²⁷

In June 2012, significant new legislation began to change the landscape for local public health agencies in North Carolina. Before that date, the law that established the option of providing public health services through a consolidated human services agency was limited to counties with populations of 425,000 or more. The option for county commissioners to assume the powers and duties of a local board of health was subject to the same population threshold. By 2012, only three North Carolina counties—Guilford, Mecklenburg, and Wake—had populations that large, and only two had exercised the options.²⁸ The new legislation removed the population threshold and extended the option of creating a consolidated human services agency to any county with a county–manager form of government. It also extended the option of abolishing the local board of health and transferring its powers and duties to the board of commissioners to all counties.²⁹ As of May 30, 2014, eighteen North Carolina counties had used their new authority under the law to change their local health department, their local board of health, or both. Several other counties were in the process of considering or planning for changes. Figures 38.1 and 38.2 demonstrate the changes that occurred during the law’s first two years. An up-to-date map of local health departments in North Carolina is maintained on the School of Government’s website.³⁰

23. For more information about North Carolina’s public health incubator collaboratives, see <http://nciph.sph.unc.edu/incubator/>.

24. G.S. 130A-34.

25. G.S. 130A-2(5) (defining “local health department” as “a district health department or a public health authority or a county health department”); 130A-43 (giving consolidated human services agencies the responsibility to carry out the duties of a local health department); 153A-77(b) (authorizing boards of county commissioners to create consolidated human services agencies that include public health). Cabarrus County provides public health services pursuant to an uncodified state law that authorizes a hospital authority to provide local public health services. S.L. 1997-502, sec. 12. The Cabarrus Health Alliance exercises the legal powers and duties of a local health department.

26. G.S. 130A-2(4) (defining “local board of health” as “a district board of health or a public health authority board or a county board of health”); 153A-77(d) (providing that a consolidated human services board acquires the powers and duties of a local board of health).

27. G.S. 153A-77(a) authorizes commissioners to directly assume the powers and duties of a board of health or a consolidated human services board. It requires the board of commissioners to give thirty days’ notice of a public hearing and hold the public hearing before adopting a resolution to abolish the appointed board.

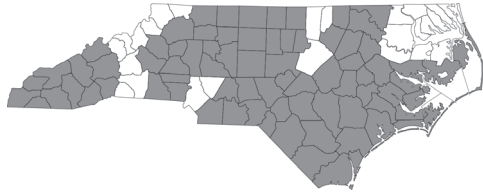
28. Wake County has provided public health services through a consolidated human services agency governed by a consolidated human services board since the mid-1990s. Mecklenburg County was the first in the state to abolish its local board of health and transfer the board’s powers and duties to the county commissioners. In 2008, Mecklenburg created a consolidated human services agency but did not appoint a consolidated board, choosing instead to maintain direct governance by the commissioners. Once it reached the population threshold imposed under prior law, Guilford County initially studied its options and elected to continue to operate a county health department governed by an appointed board of health. However, after the 2012 legislation, it revisited the issue and created a consolidated human services agency governed directly by the county commissioners in 2014.

29. S.L. 2012-126.

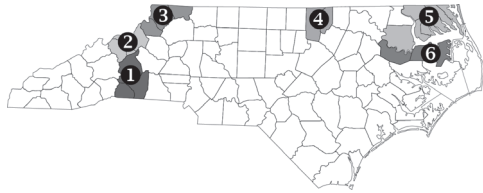
30. The map is available at www.sog.unc.edu/node/1035, under the heading “Local Public Health Agencies.”

Figure 38.1 Local Public Health Agencies and Boards in North Carolina, FY2011–2012

County health department with county board of health



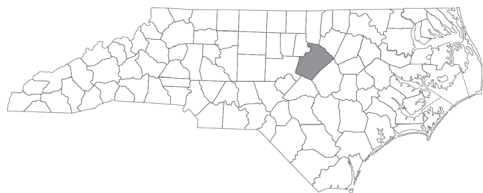
District health department with district board of health (6 districts)



Consolidated human services agency governed by board of county commissioners



Consolidated human services agency with consolidated human services board



Public health authority with public health authority board

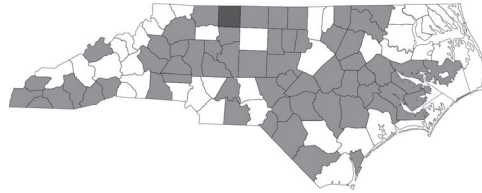


Public hospital authority with hospital board authorized to act as board of health



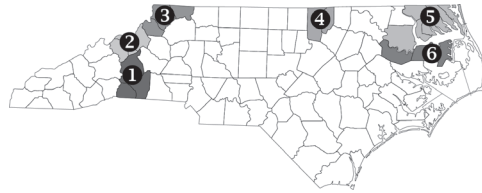
Figure 38.2 Local Public Health Agencies and Boards in North Carolina, May 30, 2014

County health department

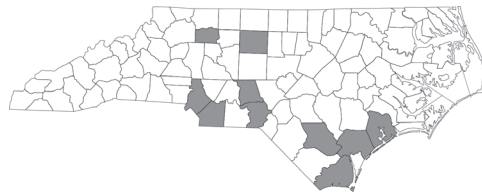


■ With county board of health
■ Governed by board of county commissioners (health advisory committee)

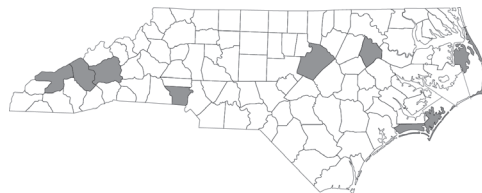
District health department with district board of health (6 districts)



Consolidated human services agency governed by board of county commissioners (health advisory committee)



Consolidated human services agency with consolidated human services board



Public health authority with public health authority board



Public hospital authority with hospital board authorized to act as board of health



County Health Departments

A county health department is a single-county agency that provides local public health services. It is created by the county commissioners and typically is governed by a board of health appointed by the commissioners.³¹ The board of health appoints a local health director after consultation with the county commissioners.³² The county health director must meet minimum education and experience requirements and has a number of legal powers and duties, which are described in greater detail in the section on local health directors later in this chapter.

District Health Departments

A district health department (sometimes called a regional health department) is a multi-county agency that provides local public health services for all the counties in the district. A district health department may be formed upon agreement of the boards of county commissioners and the boards of health of two or more counties.³³ A county may join an existing district health department upon a similar agreement entered by each affected county. A district health department may have health department offices in each component county, but it is governed by one board of health and administered by one health director.

The governing board is called a *district board of health*. Each county in the district appoints one county commissioner to serve on the board, and those commissioners appoint the remaining members.³⁴ If a county joins or withdraws from an existing district health department, the district board of health is dissolved and a new board is appointed. After consultation with the board of commissioners of each county in the district, the board of health appoints a district health director.³⁵ The district health director must meet the same minimum education and experience requirements as a county health director and has the same legal powers and duties.

Any county may withdraw from a district health department when a majority of its county commissioners determines that the district is not operating in the best interests of health in that county. The district may be dissolved upon a similar decision by the boards of commissioners of all the counties in the district. Withdrawal or dissolution may take place only after written notice is given to DHHS and only at the end of the fiscal year. A certified public accountant or an auditor certified by the Local Government Commission distributes surplus funds to the counties according to the percentage each county contributed. When an entire district dissolves or when a county withdraws, any rules adopted by the district board of health remain in effect in the county or counties involved until amended or repealed by the new board or boards governing the affected counties.³⁶

Public Health Authorities

A county may meet its obligation to provide public health services by creating a public health authority. A public health authority may be formed by a single county or by two or more counties jointly. To form a single-county public health authority, the board of commissioners and the county board of health must jointly adopt a resolution finding that it is in the interest of the public health and welfare in the county to create a public health authority and provide public health services through it. In the case of a multi-county authority, the resolution must be adopted jointly by the board of commissioners and board of health governing each affected county. A county may join an existing public health authority upon joint resolution of the board of commissioners and board of health of each county involved. Before adopting any such resolution, the county commissioners must give notice to the public and hold a public hearing.³⁷

After the resolution has been adopted, a public health authority board is appointed. The board of a single-county public health authority is appointed by the county commissioners of the county. For a multi-county public health authority, the chair of the board of commissioners of each participating county appoints one county commissioner (or designee) to the board, and those members appoint the remaining members.³⁸ The board replaces the prior local

31. G.S. 130A-35.

32. G.S. 130A-40.

33. G.S. 130A-36.

34. G.S. 130A-37.

35. G.S. 130A-40.

36. G.S. 130A-38.

37. G.S. 130A-45.02.

38. G.S. 130A-45.1.

board of health and becomes the rulemaking, policy-making, and adjudicatory body for the authority. The public health authority board appoints a public health authority director after consultation with the appropriate county commissioners.³⁹ The public health authority director must meet the same minimum education and experience requirements as a county health director and has similar legal powers and duties.

Once created, a public health authority operates more independently of the board (or boards) of county commissioners than a traditional county health department. For example, a public health authority is not required to submit its budget to the county commissioners. While it may request funding from county commissioners, the authority acts on its own to develop its budget in accordance with state financial management laws. It also may acquire or sell real property without going through the county commissioners.⁴⁰

A board of county commissioners may dissolve a public health authority (or withdraw from a multi-county authority) upon a finding that the authority is not operating in the best health interests of the county. Dissolution may occur only after written notification to DHHS and only at the end of a fiscal year. If the authority was a multi-county authority, a certified public accountant or an auditor certified by the Local Government Commission distributes surplus funds to the counties according to the percentage each county contributed. All rules adopted by the authority board continue in effect until amended or repealed by the new authority board or local board of health.⁴¹

Consolidated Human Services Agencies

A board of commissioners in a county with a county manager appointed under G.S. 153A-81 may elect to establish a consolidated human services agency (CHSA). G.S. 153A-77(b) authorizes such counties to create a CHSA to “carry out the functions of any combination of commissions, boards, or agencies appointed by the board of county commissioners or acting under and pursuant to the authority of the board of county commissioners.” It specifies that a CHSA may include public health, but it does not require public health to be included.⁴²

A consolidated human services agency typically is governed by a consolidated human services board. If the CHSA includes public health, the consolidated human services board acquires the powers and duties of a local board of health, with one exception: the board is not authorized to appoint the agency’s director. Instead, the director is appointed by the county manager with the advice and consent of the board. The consolidated board also has its own powers and duties set forth in the CHSA statute (G.S. 153A-77(d)).

A consolidated human services agency is administered by a consolidated human services director. If the CHSA includes public health, the director must appoint a person who meets the education and experience requirements for a local health director set out in G.S. 130A-40.⁴³ The consolidated human services director acquires most of the legal powers and duties of a local health director, with two provisos: (1) the director may serve as the CHSA’s executive officer only to the extent and in the manner authorized by the county manager, and (2) the director may appoint CHSA staff

39. G.S. 130A-45.5.

40. Other ways in which a public health authority differs from conventional county or district health departments are explored in more detail at www.sog.unc.edu/node/2358.

41. G.S. 130A-45.2.

42. The state law governing CHSAs was changed significantly by legislation enacted in June 2012. S.L. 2012-126 (amending G.S. 153A-77). Under prior law, the only counties that could create CHSAs were those with populations exceeding 425,000. Further, CHSAs were required to include public health, social services, and mental health, developmental disabilities, and substance abuse services. The 2012 legislation removed the population threshold and amended the language describing a CHSA, with the result that counties have a great deal of flexibility in determining which services will be provided. On March 1, 2013, there were nine CHSAs in North Carolina, and all of them provided public health services, but it is possible that at a later date the state may have counties with CHSAs that do not provide public health services.

There are some limitations on what may be included in a CHSA. Among other things, G.S. 153A-76 prohibits county commissioners from including a public health authority in a CHSA. However, a separate law permits commissioners to dissolve or withdraw from a public health authority at the end of a fiscal year. A county that is part of a public health authority could therefore create a CHSA including public health, but the commissioners would have to take the additional step of dissolving or withdrawing from the authority first. Similarly, a county that is presently part of a multi-county district health department could not include public health in a CHSA without first withdrawing from the district at the end of a fiscal year.

43. G.S. 153A-77(e)(9). The county manager must approve the appointment. If the CHSA director meets the statutory requirements for a local health director, there is no need for a separate individual to be appointed.

only with the approval of the county manager.⁴⁴ The director may exercise those powers and duties directly or delegate them to the appointee with local health director qualifications or other appropriate persons.⁴⁵

Governance: Local Boards of Health

Each local public health agency in North Carolina has a governing board that is responsible for public health within its jurisdiction. What the board is called varies by agency: a county health department has a county board of health, a district health department has a district board of health, a public health authority has a public health authority board, and a consolidated human services agency has a consolidated human services board. The generic term *local board of health* embraces all of these types of boards when they are carrying out public health duties.⁴⁶ A board of health may be an independent board appointed by the county commissioners, or the commissioners may elect to serve as the board of health themselves by adopting a resolution abolishing the board and conferring its powers and duties upon the board of commissioners.⁴⁷

The composition of the different types of boards varies, as illustrated in Table 38.1. In general, board members are county commissioners, professionals with expertise in health care or public health (including physicians, pharmacists, veterinarians, and professional engineers, among others), and the general public. The powers and duties of each type of board also vary somewhat, but each is charged with protecting and promoting the public health and with serving as the policy-making, rulemaking, and adjudicatory body for public health in the county or counties in its jurisdiction. Each board has limited authority to set fees for public health services. Each board also influences the day-to-day administration of the local health department, public health authority, or consolidated human services agency.

Board Membership Qualifications and Terms

The statutes authorizing county boards of health, district boards of health, and consolidated human services boards all require that board members be residents of the county or district. For county and district boards, if there is no resident available to serve in one of the licensed professional positions, a member of the general public must be appointed instead.⁴⁸ There is no similar provision for consolidated human services boards, suggesting that a licensed professional position on such a board would simply remain vacant if there were no resident available to serve. Members of public health authority boards are not required to be residents of the county or multi-county area served by the authority.

County and district board of health members are appointed to three-year terms and may serve a maximum of three consecutive three-year terms. There are a couple of exceptions to this general rule. First, if the member is the only county or district resident who is a member of one of the licensed professions that must be represented on the board, the member may serve more than three consecutive three-year terms.⁴⁹ Second, if a member of a district board of health is serving in his or her capacity as a county commissioner, the North Carolina Attorney General has advised that the member may serve for as long as he or she remains a commissioner, even if that time exceeds three consecutive three-year terms.⁵⁰ Consolidated human services board members are appointed to four-year terms and may serve a maximum of two consecutive four-year terms. There is no exception for a situation in which a member is the only county resident who is a member of a licensed profession that must be represented on the board.⁵¹ The county com-

44. G.S. 130A-43(c).

45. G.S. 130A-6 authorizes an official with authority granted by Chapter 130A to delegate that authority to another person.

46. This is consistent with statutory definitions and usage. G.S. 130A-2(4) defines “local board of health” to mean “a district board of health or a public health authority or a county board of health.” G.S. 153A-77(d) gives consolidated human services boards the powers and duties of local boards of health, except when the statutes specifically provide otherwise.

47. G.S. 153A-77(a) authorizes commissioners to directly assume the powers and duties of a county board of health or a consolidated human services board. It requires the board of commissioners to give thirty days’ notice of a public hearing and hold the public hearing before adopting a resolution to abolish the appointed board.

48. There is an exception for the member of a *county* board of health who serves in the licensed optometrist spot. G.S. 130A-35(b). If a licensed optometrist who is a county resident is not available for appointment, the county commissioners may fill the position with either (1) a licensed optometrist who resides in another county, or (2) a member of the general public who is a county resident. This provision does not apply to a *district* board of health.

49. G.S. 130A-35(c) (county board of health); 130A-37(c) (district board of health).

50. Attorney General Advisory Opinion to Hal G. Harrison, Mitchell County Attorney, 1998 WL 856356 (Oct. 8, 1998).

51. G.S. 153A-77(c).

Table 38.1 Board Membership Requirements by Type of Local Public Health Agency Board*

	County Board of Health	District Board of Health	Single-County Public Health Authority Board	Multi-County Public Health Authority Board	Consolidated Human Services Board
Number of members	11	15 to 18	7 to 9	7 to 11	Up to 25
Members of the public or consumers	3	✓	✓	✓	4 or more ^c
County commissioner	✓	✓ ^a	✓	✓ ^b	✓
Physician	✓	✓	✓	✓	✓ ^d
Psychiatrist					✓
Psychologist					✓
Social worker					✓
Hospital administrator			✓	✓	
Dentist	✓	✓	✓	✓	✓
Optometrist	✓	✓	✓	✓	✓
Veterinarian	✓	✓	✓	✓	✓
Registered nurse	✓	✓	✓	✓	✓
Pharmacist	✓	✓	✓	✓	✓
Engineer	✓	✓	✓	✓	✓
Accountant			✓	✓	

Shaded area: Two professionals representing the following fields must serve on the board: optometry, veterinary science, nursing, pharmacy, engineering, or accounting. In other words, not *all* of these professions will necessarily be represented.

* These requirements do not apply if the county commissioners serve as the board for a county health department or a consolidated human services agency including public health.

- a. One commissioner from each county involved.
- b. One commissioner from each county involved. The commissioners may designate someone other than a commissioner to serve in this position.
- c. At least four members must be consumers of human services.
- d. Two licensed physicians must serve on the board, one of whom must be a psychiatrist.

missioner member of the board may serve only as long as he or she remains a county commissioner. Public health authority board members are appointed to three-year terms, and there is no limit on the number of terms they may serve.⁵² If the county commissioners are serving as the board of health, a person's service as a board of health member ends when his or her service as a county commissioner ends.

An appointed board of health member may be removed from office if there is cause for removal under state law. The laws for county and district boards of health, consolidated human services boards, and public health authority boards all state that a member may be removed for any of the following reasons:⁵³

- Commission of a felony or other crime involving moral turpitude
- Violation of a state law governing conflict of interest

52. G.S. 130A-45.1.

53. G.S. 130A-35(g) (county board of health); 130A-37(h) (district board of health); 130A-45.1(j) (public health authority board); 153A-77(c) (consolidated human services board). If the board of commissioners is serving as the board of health, these sections do not apply.

- Violation of a written policy adopted by the county commissioners (or all of the applicable boards of commissioners, if it is a multi-county board)
- Habitual failure to attend meetings
- Conduct that tends to bring the office into disrepute
- Failure to maintain qualifications for appointment (for example, professional licensure, residency in the county, and so forth)

Rulemaking

A local board of health has the duty to protect and promote the public health and the authority to adopt rules necessary to those purposes.⁵⁴ A board of health rule is valid throughout the county or counties in the board's jurisdiction, including within any municipalities served by the board.⁵⁵

There are several limitations to the board's rulemaking authority that are set out in statutes:

- A board may not adopt rules concerning the issuing of grades and permits to food and lodging facilities or the operation of those facilities (G.S. 130A-39(b)).
- A board may issue its own regulations regarding on-site wastewater management only with the approval of DHHS, which must find that the proposed rules are at least as stringent as state rules and are necessary and sufficient to safeguard the public health (G.S. 130A-39(b); 130A-335(c)).⁵⁶
- A board of health rule regulating smoking in public places must abide by statutory restrictions on this authority and must be approved by the applicable board(s) of county commissioners (G.S. 130A-498).

Additional limitations on the rulemaking authority have been imposed by state courts. The North Carolina Supreme Court has held that a local board of health rule may be preempted by state law if the state has already provided a complete and integrated regulatory scheme in the area addressed by the local rule. However, state law expressly permits a board to adopt a more stringent local rule even in the presence of statewide rules on the same issue if a more stringent rule is required to protect the public health.⁵⁷ The supreme court has interpreted this to mean that a board adopting a more stringent rule must provide a rationale for local standards that exceed the statewide standards. To do this, the board likely needs to be able to demonstrate that conditions in the board's jurisdiction are different from the rest of the state in a way that warrants higher standards.⁵⁸

In addition, the North Carolina Court of Appeals has enunciated a five-part test that a local board of health rule must satisfy to be valid. The rule must

1. be related to the promotion or protection of health,
2. be reasonable in light of the health risk addressed,
3. not violate any law or constitutional provision,

54. G.S. 130A-39.

55. G.S. 130A-39(c) ("The rules of a local board of health shall apply to all municipalities within the local board's jurisdiction.")

56. If a local board of health adopts rules governing wastewater collection, treatment, and disposal, then it must also adopt rules for imposing administrative penalties when the local wastewater rules are violated (G.S. 130A-22(h)).

57. G.S. 130A-39(b).

58. See *Craig v. Cnty. of Chatham*, 356 N.C. 40 (2002). The *Craig* court considered two local actions regulating swine farms: an ordinance adopted by the Chatham County Board of Commissioners and a rule adopted by the Chatham County Board of Health. The court held that both the ordinance and the rule were preempted by state statutes that amounted to a complete and integrated regulatory scheme for swine farms. *Id.* at 50. However, the court acknowledged that local boards of health may regulate an area already subject to a comprehensive statewide regulatory scheme in some circumstances. G.S. 130A-39 specifically authorizes local boards of health to adopt more stringent rules in areas that are already subject to statewide regulation by the Commission for Health Services or the Environmental Management Commission, but only when a more stringent local rule is necessary to protect the public health. The court concluded that this statute does not authorize a local board of health to "superimpose additional regulations without specific reasons clearly applicable to a local health need." *Id.* at 51–52. The court noted that the board of health had not provided "any rationale or basis for making the restrictions in Chatham County more rigorous than those applicable to and followed by the rest of the state, and it invalidated the rule on that basis. *Id.* at 52.

4. not be discriminatory, and
5. not make distinctions based upon policy concerns traditionally reserved for legislative bodies.⁵⁹

Before adopting, amending, or repealing any local rule, the board of health must give the public notice of its intent and offer the public an opportunity to inspect its proposed action. Ten days before the proposed action is to occur, notice of the proposal must be published in a local newspaper with general circulation. The notice must contain a statement of the substance of the proposed rule or a description of the subjects and issues involved, the proposed effective date, and a statement that copies of the proposed rule are available at the local health department. At the same time, the board must make the text of the proposed rule, amendment, or rule to be repealed available for inspection by placing it in the office of each county clerk within the board's jurisdiction.

Imposing Fees

A local board of health may impose a fee for many services rendered by the health department.⁶⁰ County and district boards of health and consolidated human services boards must base their fees on a plan proposed by the local health director, and any fees adopted by the board must be approved by the county commissioners (in the case of a district health department, all applicable boards of county commissioners). Public health authority boards may establish fee schedules and are not required to obtain commissioner approval.

There are some limitations to a board's fee-setting authority. First, a board may not charge fees for services rendered by a health department employee acting as an agent of the state. This covers most environmental health programs, but there are exceptions: cost-related fees may be charged for services provided under the on-site wastewater treatment program, the public swimming pools program, the tattooing regulation program, and the local program for inspecting and permitting drinking water wells.⁶¹

Second, while local health departments may charge fees for some of their clinical services, the local board of health has limited discretion in determining the amount of the fee. Fees may reflect Medicaid reimbursement rates established by the state Division of Medical Assistance or fees set by a state or federal program that provides funds for a particular service. Also, local health departments are specifically prohibited by state law from charging health department clients for the following services:⁶²

- Testing and counseling for sickle cell syndrome⁶³
- Examination for and treatment of tuberculosis⁶⁴
- Examination for and treatment of certain sexually transmitted diseases⁶⁵
- Testing and counseling for HIV⁶⁶

Additionally, immunizations that are required by law and supplied by the state must be provided at no cost to uninsured or underinsured patients with family incomes below 200 percent of the federal poverty level.⁶⁷

Sometimes federal laws affect a local health department's ability to set fees or charge clients for services. For example, Title VI of the federal Civil Rights Act of 1964 prohibits recipients of federal financial assistance from charging their

59. *City of Roanoke Rapids v. Peedin*, 124 N.C. App. 578 (1996).

60. G.S. 130A-39(g); 130A-45.3(a)(5); 153A-77(d)(1).

61. G.S. 130A-39(g).

62. Sometimes a third-party payer such as Medicaid provides reimbursement for one of the listed services. A local health department may bill a third-party payer for the services, but it may not bill the client.

63. G.S. 130A-130.

64. G.S. 130A-144(e).

65. *Id.*

66. 10A N.C.A.C. 41A .0202(9).

67. G.S. 130A-153(a).

limited-English proficient clients for interpretation services.⁶⁸ Similarly, the federal HIPAA medical privacy rule limits the fees that may be charged for copies of medical records.⁶⁹

Adjudicating Disputes

In some circumstances, a local board of health acts as an adjudicatory body.⁷⁰ When a person is aggrieved by the local health department's interpretation or enforcement of a local board of health rule, or the local imposition of administrative penalties, the person may appeal the department's decision to the board of health. The board hears the case and issues a written decision either upholding or overturning the department's decision. The rules of evidence that are enforced in courtrooms do not apply at the board hearing, but the board's decision must be supported by adequate evidence. The board must put its decision in writing and state the factual findings upon which it is based. If the person is not satisfied with the board of health's decision, he or she may appeal to district court. The procedures and time frames for actions are set out in G.S. 130A-24(b) through (d).

When a person is aggrieved by the local health department's enforcement of state rules, such as the food and lodging rules, the local board of health is not authorized to hear the appeal. Those cases go to the state Office of Administrative Hearings.⁷¹

Local Health Department Administration

The administrative functions within local health departments include managing operations and programs; providing in-service training for staff; preparing the budget; explaining the department's activities to the board of health, local elected officials, and the public; informing the public of health laws and rules as well as enforcing them; suggesting new rules and services; and purchasing equipment and supplies. These duties generally are the local health director's responsibility, but the management of particular functions may differ from county to county.

Local Health Directors

The local health director is essentially the chief executive officer of the local public health agency—he or she administers the department and exercises specific powers and duties that are prescribed by law. The term *local health director* includes the director of a county health department, a district health department, or a public health authority, as well as the director of a consolidated human services agency or his or her designee.⁷² A director of a county or district health department or a public health authority must meet minimum education and experience requirements.⁷³ In general, the director must have education and experience in medicine, public health, or public administration related to health.⁷⁴ A consolidated human services director is not required by statute to meet particular education or experience requirements. However, a consolidated human services director who does not satisfy the statutory qualifications

68. See Voluntary Compliance Agreement between the Office for Civil Rights, U.S. Department of Health and Human Services, and N.C. Department of Health and Human Services, www.sog.unc.edu/sites/www.sog.unc.edu/files/2004DHHSTitle6VCA.pdf.

69. 45 C.F.R. § 164.524(c)(4).

70. G.S. 130A-24.

71. G.S. 130A-24(a).

72. The term "local health director" is defined by statute to mean "the administrative head of a local health department appointed pursuant to this Chapter." The same statute defines "local health department" as "a district health department or a public health authority or a county health department." G.S. 130A-2. Although these definitions do not capture consolidated human services agencies and directors, a separate statute assigns local public health roles to the agency by (1) giving the agency "the responsibility to carry out the duties of a local health department"; (2) providing that the consolidated human services board "shall have all the powers and duties of a local board of health" except for appointing the director and transmitting or presenting the budget for local health services; and (3) stating that "a human services director shall have all the powers and duties of a local health director provided under G.S. 130A-41," except that the human services director's activities in managing the department are subject to the oversight of the county manager and the human services director may appoint agency staff only with the county manager's approval.

73. G.S. 130A-40(a); 130A-45.4.

74. Another law provides for a limited pilot program (one county only) to allow a person with education and experience in public health nursing to serve as a local health director, as long as the appointment is approved by the N.C. Secretary of Health and Human Services. G.S. 130A-40.1.

for a local health director must appoint a person who does.⁷⁵ In addition, North Carolina's standards for local public health agency accreditation specify that the agency's governing board must appoint a local health director who meets the requirements of the law that applies to county and district health directors.⁷⁶

The appointment of the local health director varies by type of local public health agency. For a county or district health department, the local health director is appointed by the local board of health after consultation with all applicable boards of county commissioners. Although the board must consult with the commissioners, the commissioners are not required to approve the appointment.⁷⁷ The same procedure is followed by a public health authority board when it appoints the public health authority director.⁷⁸ A consolidated human services agency director is appointed by the county manager with the advice and consent of the consolidated human services board.⁷⁹ If the county commissioners have abolished the board of health and assumed direct control of the health department pursuant to G.S. 153A-77(a), then the commissioners have all the powers and duties of the local board of health, including the power to appoint the local health director. This is the only circumstance in which the county commissioners may directly appoint the local health director.

All local health directors have powers and duties that come from multiple sources of law.⁸⁰ A local health director's powers and duties fall into five general categories:

1. **Administration.** The local health director administers programs under the direction of the board of health. All types of local health directors have the authority to employ and dismiss health department staff, but the employment decisions of a director of a consolidated human services agency must be approved by the county manager. In addition, the director of a county health department, a district health department, or a consolidated human services agency may enter contracts on behalf of the department, but the law that gives local health directors this authority also states that it shall not "be construed to abrogate the authority of the county commissioners."⁸¹ Thus, it is a common practice to have county managers involved in the approval or execution of health department contracts.
2. **Remedies.** The local health director is responsible for enforcing public health laws within his or her jurisdiction and may employ a number of legal remedies when public health laws are violated. The director may
 - initiate civil or criminal proceedings against a public health law violator,⁸²
 - abate public health nuisances or imminent hazards,⁸³

75. G.S. 153A-77(e).

76. See 10A N.C.A.C. 48B .1304; *see also* 10A N.C.A.C 48B .0901(b)(1) (requiring the agency to have, or be recruiting, a local health director who meets legal requirements for the position).

77. G.S. 130A-40.

78. G.S. 130A-45.4.

79. G.S. 153A-77(e).

80. The main statutes setting forth the powers and duties of local health directors are G.S. 130A-41 (county and district health directors); 153A-77(e) (consolidated human services directors); and 130A-45.5(c) (public health authority directors). However, other powers and duties appear in several other statutes in G.S. Chapter 130A. Except as otherwise noted, the powers and duties discussed in this section of the chapter either originate in or are cross-referenced in G.S. 130A-41.

81. G.S. 130A-41(b)(13). A public health authority director does not have the power to enter contracts. Instead, the public health authority board holds that power. The board could, however, delegate contracting authority to the director or another agent or employee. G.S. 130A-45.3(a)(9) (allowing the public health authority board to "delegate to its agents or employees any powers or duties as it may deem appropriate").

82. G.S. 130A-18 authorizes the local health director to institute an action for injunctive relief in superior court. G.S. 130A-25 makes violation of most state and local public health laws or rules a class 1 misdemeanor (see also G.S. 14-3, providing for the classification of misdemeanors). However, violations of laws and rules pertaining to smoking in public places may not be prosecuted as misdemeanors. G.S. 130A-497(d). Further, in counties in which the county commissioners have assumed the role of the local board of health, the commissioners are authorized to enforce local rules through civil penalties—an option that is not available in counties with other forms of public health governance. G.S. 153A-77(a). However, if the commissioners exercise the option to impose a civil penalty, violation of the local rule subject to the penalty is *not* a misdemeanor unless the rule specifically states that it is.

83. G.S. 130A-19 (public health nuisance); 130A-20 (imminent hazard).

- impose administrative penalties (fines) for violations of state or local laws regulating smoking in public places,⁸⁴
- embargo food or drink in some circumstances,⁸⁵
- impose administrative penalties for violations of local on-site wastewater rules, or conditions imposed on permits issued under such rules.⁸⁶

The local health director may also play a role in actions taken by local public health employees to suspend or revoke permits, such as a permit to operate a restaurant.⁸⁷

- 3. Communicable disease control.** The local health director must investigate cases and outbreaks of communicable diseases and ensure that communicable disease control measures are given.⁸⁸ The director may order isolation or quarantine if the legal conditions for exercising the isolation or quarantine authority are met.⁸⁹ The local health director also has the duty to enforce the North Carolina laws requiring the immunization of children.
- 4. Other disease control.** The local health director must examine, investigate, and control rabies in accordance with state public health laws. The director must also investigate the causes of other diseases in the jurisdiction, whether or not they are communicable.
- 5. Educate and advise.** The local health director must disseminate public health information, promote the benefits of good health, and advise local officials about public health matters.

This list is not exhaustive. Local health directors are responsible for the overall operation of the local public health agency, which makes the director ultimately accountable for administrative activities associated with the agency's performance of local public health services and functions. A consolidated human services director also has duties that go beyond those of a traditional local health director, largely reflecting the consolidated human services director's role as the chief administrator for human services programs other than public health.

Most of the powers and duties of a local health director may be delegated to another person. However, the director's authority to embargo food and drink in some circumstances may not be delegated.⁹⁰

Local Health Department Personnel

In addition to a director, each type of local public health agency must have certain other staff members. A state regulation that addresses minimum staffing requires each local health department to employ a health director, a public health nurse, an environmental health specialist, and a secretary.⁹¹ In general, these staff members must be full-time employees, but there is an exception that allows an agency to share a health director with another agency. The local health department accreditation rules also address staffing both directly and indirectly. One of the accreditation standards requires a local agency to employ or contract with one or more licensed physicians to serve as medical director.⁹² Portions of the accreditation rules refer to other categories of staff members or to specific expertise that the agency

84. G.S. 130A-22(h1).

85. G.S. 130A-21.

86. G.S. 130A-22(h). Most North Carolina counties do not have local on-site wastewater rules. Rather, the state rules apply within the county and different remedies are available.

87. See G.S. 130A-23, authorizing the secretary of Health and Human Services to revoke or suspend permits upon finding a violation of state environmental health laws. Although the power to exercise this remedy is given to a state official, in practice violations are discovered and permit actions are taken by local environmental health specialists acting under the supervision of the local health director.

88. G.S. 130A-144.

89. G.S. 130A-145.

90. G.S. 130A-6; 130A-21(a).

91. 10A N.C.A.C. 46 .0301(a).

92. 10A N.C.A.C. 48B .0901(b)(3). It is possible for an agency to be accredited without satisfying every standard. The accreditation rules establish benchmarks and specify how many benchmarks must be met in each of three areas: agency core functions and essential services, facilities and administrative services, and board of health. 10A N.C.A.C. 48B .0103. The medical director provision falls under agency core functions and essential services. An agency could skip the medical director provision and still be accredited if it met enough of the other benchmarks in that area.

must possess or have access to, but they do not explicitly require the agency to have staff positions for those categories or expertise.⁹³

There are no other requirements in law for specific numbers or types of staff, but local health departments need sufficient personnel to provide public health services and to perform all the activities and functions associated with other duties of the health department (such as assuring compliance with state and federal laws). Many departments employ or contract with a number of health care providers and environmental health specialists, as well as health educators, social workers, medical records specialists, epidemiologists or statisticians, and administrative staff.

The employees of county and district health departments ordinarily are subject to the North Carolina State Human Resources Act (SHRA) (G.S. 126-5(a)(2)).⁹⁴ Public health authorities are exempt from the SHRA and establish their own personnel policies and salary plans.⁹⁵ The employees of consolidated human services agencies are subject to county personnel policies or ordinances, unless the board of county commissioners elects to make the CHSA employees subject to the SHRA.⁹⁶ When the agency employees are covered by the SHRA, their qualifications and terms of employment are governed by the rules of the State Human Resources Commission.

The hiring authority for local health department employees varies by agency type. The director of a county or district health department is authorized to employ or dismiss department employees in accordance with the SHRA.⁹⁷ The director of a public health authority is authorized to employ, discipline, and dismiss employees of the authority.⁹⁸ The director of a consolidated human services agency may appoint employees, but the appointments must be approved by the county manager.⁹⁹

Financing of Local Public Health Services

Public health activities in North Carolina are financed at the state level through federal funds, state funds, private grants, and fees. The precise mix of funds to support local public health services varies by locality.

Federal and State Funds

Local health departments receive federal funds both directly and indirectly. Indirect federal support comes from federal funds that are paid to the state and then channeled by the state to the local agencies. Federal categorical funds support maternal and child health services, family planning, the WIC (special supplemental nutrition for women, infants, and children) program, and several other services and programs. The major source of direct support is the state Medicaid program, which in fiscal year 2012 was composed of about 65 percent federal funds and 35 percent state funds.¹⁰⁰ Medicaid provides direct reimbursement for services to Medicaid-eligible clients, as well as an annual cost settlement. Some local health departments also receive federal funds in the form of Medicare reimbursement for services such as home health or diabetes care.

The state provides general aid-to-county funds, which are distributed to local public health agencies by DHHS. Funds are allocated based on population and utilization of allocated funds.¹⁰¹ The state health director may allocate special

93. See, e.g., 10A N.C.A.C. 48B .0203 (directing agency to assure staff have expertise in data management); 48B .0301 (requiring access to and consultation with an epidemiologist); 48B .0701 (referring to unit directors for communicable disease, nursing, and environmental health).

94. Local health department employees may be removed from SHRA coverage if the State Human Resources Commission determines that the local personnel system is substantially equivalent to the SHRA. G.S. 126-11(a).

95. G.S. 130A-45.12; 130A-45.3(a)(7).

96. G.S. 153A-77(d).

97. G.S. 130A-41(b)(12).

98. G.S. 130A-45.5(c)(12).

99. G.S. 153A-77(e)(1); 130A-43(c)(2).

100. Source: Kaiser Family Foundation, Federal and State Share of Medicaid Spending, kff.org/medicaid/state-indicator/federalstate-share-of-spending/. The match rate varies from state to state and may vary from year to year.

101. 10A N.C.A.C. 46 .0101.

needs funds to local health departments that demonstrate a critical public health need, unique to the department's service area, that cannot be met through other funding mechanisms.¹⁰² Additional support comes from categorical grants, which may include a combination of federal and state funds. The state also awards other grant or contract funds for special projects. Finally, the state reimburses some services on a fee-for-service basis.

To receive state funds and federal funds that the state distributes, a local health department must sign a contract with DHHS called the *consolidated agreement*. The consolidated agreement contains a number of general provisions governing how local health departments must use and account for money flowing from the state, as well as provisions that set out special requirements for the use of certain funds. If a department fails to comply with the terms of the contract, the state may take steps to cut off state funding for the program that is out of compliance. The state first notifies the department that it has sixty days to comply. If the problem is not corrected to the satisfaction of the state within that period, the state may temporarily suspend funding for the program that is out of compliance. If the deficiency remains uncorrected thirty days after the temporary suspension, program funds may be permanently suspended until the department provides evidence that the deficiencies have been corrected. After all other reasonable administrative remedies have been exhausted, the state may cancel, terminate, or suspend the contract in whole or in part and the department may be declared ineligible for further state contracts or agreements. Alternatively, the state can enforce the contract by suing the county. Neither of these actions has ever been taken by the state against a county; nevertheless, the ability to withhold funds gives the state some leverage to require certain levels of service by local public health agencies.

Local Sources of Revenue

County Appropriations

Local boards of health have no power to tax, so a board and its department must depend on other sources for funds. Boards of county commissioners are authorized to appropriate funds from property tax levies and to allocate other revenues whose use is not otherwise restricted by law for the local health department's use.

For county health departments, county commissioners approve the health department budget as a regular part of their responsibility for county finance. For consolidated human services agencies, the budget for public health is a part of the budget planned by the consolidated human services director, recommended by the consolidated human services board, and approved by the county commissioners. Public health authorities and district health departments prepare and approve their own budgets and need not obtain county commissioners' approval. These agencies seek county appropriations, however, and the county commissioners must approve those expenditures.

In the past, there was no minimum level of local funding that county commissioners were required to provide for public health. Local health departments worked with county governments to try to ensure that funding was sufficient to support the services and functions that the health department performed, and the amount appropriated for public health services varied widely from county to county.¹⁰³ Legislation adopted in 2012 imposed a maintenance-of-effort requirement for local public health.¹⁰⁴ Effective July 1, 2014, in order to receive state and federal funding for local public health, a county government must maintain its operating appropriations to its local health department from local ad valorem tax receipts at levels equal to amounts appropriated in state fiscal year 2010–11.¹⁰⁵ Two additional non-supplantation provisions in the statutes prohibit reductions of county appropriations when state money increases in certain circumstances. G.S. 130A-4.2 requires the state DHHS to ensure that local health departments do not reduce county appropriations for health promotion services because of state appropriations. G.S. 130A-4.1 places the same requirement on maternal and child health services.

102. 10A N.C.A.C. 46 .0102.

103. A study conducted by the School of Government in 2012 examined funding for local health departments in greater detail and found wide variations in the proportion of local health department budgets that were from county appropriations versus other sources. See *Comparing North Carolina's Local Public Health Agencies: The Legal Landscape, the Perspectives, and the Numbers* (May 2012), at 39–45, www.sog.unc.edu/sites/www.sog.unc.edu/files/REPORT%20Comparing%20North%20Carolina%20Local%20Public%20Health%20Agencies_0.pdf.

104. S.L. 2012-126, sec. 3.

105. G.S. 130A-34.4(a)(2).

Grants

Local health departments may receive grants from government agencies or from private entities, such as foundations. These grants are essentially contracts between the local health department and the granting agency and usually are provided to enable the department to develop a particular project or provide a specific service.

Local Fees

Public health agencies may charge and collect fees, as described earlier in this chapter. Revenues from fees imposed by local boards of health must be used for public health purposes.

Management of Local Funds

All funds received or spent at the local level must be budgeted, disbursed, and accounted for in accordance with the Local Government Budget and Fiscal Control Act (G.S. Ch. 159, Art. 3). The budgeting, disbursing, and accounting for a county health department or consolidated human services agency is done by the county's budget officer and finance officer. District health departments and public health authorities (both single-county and multi-county) are responsible for performing these functions themselves.

Local Public Health Services

Local public health agencies provide services at both the community and individual level. While there is no single law describing the minimum services that a local agency must provide, there are three primary state laws that affect the scope and range of local service provision.

The first of these is a law that describes the public health services that the General Assembly has determined are essential to promoting and contributing to the highest levels of health and that should be available to everyone in the state.¹⁰⁶ This law incorporates the "ten essential public health services," a nationally recognized set of services that was adopted in 1994 by a national committee charged with providing a framework for effective public health systems,¹⁰⁷ and directs local health departments to ensure that the services are available and accessible to the population served by the department. The ten essential public health services fall into three categories: assessment of community health status and health problems; policy development to educate the community about health, solve community health problems, support individual and community health, and protect health and ensure safety; and assurance of quality public health and public and private health care services within the community. Table 38.2 identifies the specific services in each category.

Another law requires each local public health agency in the state to be accredited by the North Carolina Local Health Department Accreditation Board.¹⁰⁸ To be accredited, a local agency must satisfy accreditation standards that address the agency's capacity to provide the ten essential public health services, as well as several additional duties imposed by state law.¹⁰⁹ The accreditation standards are divided into three categories: agency core functions and essential services, facilities and administrative services, and local boards of health. The accreditation board assesses a local health department's performance of 148 specific activities. A health department must satisfactorily perform about 90 percent of the activities in order to obtain or maintain accreditation.¹¹⁰

106. G.S. 130A-1.1.

107. See www.cdc.gov/nphsp/essentialServices.html.

108. G.S. 130A-34.1.

109. 10A N.C.A.C. Ch. 48.

110. The accreditation rules specify the exact number of activities that must be satisfied in each category for the department to be accredited. 10A N.C.A.C. 48B .0103(a).

Table 38.2 Essential Public Health Services (G.S. 130A-1.1)

Category	Services
Assessment	Monitoring health status to identify community health problems
	Diagnosing and investigating health hazards in the community
Policy development	Informing, educating, and empowering people about health issues
	Mobilizing community partnerships to identify and solve health problems
	Developing policies and plans that support individual and community health efforts
Assurance of services	Enforcing laws and regulations that protect health and ensure safety
	Linking people to needed personal health care services and ensuring the provision of health care when otherwise unavailable
	Ensuring a competent public health workforce and personal health care workforce
	Evaluating effectiveness, accessibility, and quality of personal and population-based health services
	Conducting research

A third statute authorizes the North Carolina Commission for Public Health to establish standards for the nature and scope of local public health services.¹¹¹ The commission has adopted rules, known as the *mandated services rules*, which specify some of the public health services that local public health agencies must guarantee.¹¹² The mandated services rules address thirteen types of services that fall into one of two categories: (1) services that the local agency must provide under the direction of the local health director and the supervision of the local board of health or (2) services that a county may provide through the local agency, contract with another entity to provide, or not provide at all if the local agency can certify to the state's satisfaction that the services are available in the county from other providers. Each of the mandated services has its own rule that identifies more specifically which services must be provided or assured. Figure 38.3 identifies the mandated services.

These laws provide a starting point for understanding local public health services, but they do not paint the complete picture. Local public health agencies also must provide services or perform activities to comply with other laws. For example, in order to comply with the federal HIPAA medical privacy rule, local health departments must develop and maintain numerous forms, notices, and policies and procedures for keeping health information confidential and secure and honoring individuals' rights regarding their health information.¹¹³

The North Carolina Department of Health and Human Services conducts a biennial survey of services that are provided by local public health agencies in North Carolina, which provides additional insight into the range of local public health services that are provided by the state's local agencies. The services that are typically included in the survey cover a wide range of activities, from epidemic investigations, to school nursing services, to childhood lead poisoning prevention, to chronic disease control, to name just a few.¹¹⁴

111. G.S. 130A-9.

112. 10A N.C.A.C. 46 .0201-.0216.

113. 45 C.F.R. Parts 160, 163, and 164.

114. A list of the 127 specific services that were included in DHHS's survey for fiscal year 2011 is available at www.sog.unc.edu/sites/www.sog.unc.edu/files/Comparing%20North%20Carolina%20Local%20Public%20Health%20Agencies%20AppB_0.pdf.

Figure 38.3 Mandated Public Health Services in North Carolina (10A N.C.A.C. 46 .0201–.0216)**Local health department must provide**

- Food, lodging, and institutional sanitation
- Individual on-site water supply
- Sanitary sewage collection, treatment, and disposal
- Communicable disease control
- Vital records registration

Local health department must provide, contract for, or certify available

- Adult health
- Home health
- Dental public health
- Grade A milk certification*
- Maternal health
- Child health
- Family planning
- Public health laboratory

*In 2011, responsibility for milk sanitation at the state level was transferred from the former Division of Environmental Health, Department of Environment and Natural Resources, to the Food and Drug Protection Division of the Department of Agriculture and Community Services. S.L. 2011-145, sec. 13.3.(b).

Other Statewide Public Health Programs with Local Components

The focus of this chapter has been on the state and local system for carrying out the core public health functions that are reflected in the statute setting forth the mission and purpose of the state's public health system.¹¹⁵ The bulk of the state's public health laws and structure are focused on those functions and the duties that accompany them. However, the North Carolina public health code also addresses a number of other governmental functions and duties related to the protection of the public health. Two statewide programs that have significant local involvement are the medical examiner system and the vital records program.

Medical Examiner System

North Carolina has a centralized, state-administered medical examiner system for postmortem investigations.¹¹⁶ The system is composed of a chief medical examiner (CME), a central staff of professionals, and a network of county medical examiners. Its purpose is to investigate and determine the cause and manner of deaths that are unattended, in order to ensure that appropriate medico-legal follow-up occurs when a death is suspicious or unnatural.

The chief medical examiner is appointed by the state secretary of health and human services. By statute, the CME must be a forensic pathologist who is certified by the American Board of Pathology and licensed to practice medicine.¹¹⁷ The CME has a staff that includes pathologists, toxicologists, and other professionals who assist with autopsies and forensic investigations. Although county medical examiners are responsible for investigating deaths within their jurisdictions, the CME has oversight of all cases and may assume jurisdiction over any case or reassign a case to another

115. G.S. 130A-1.1.; see also note 2 and accompanying text.

116. G.S. Ch. 130A, Art. 16; 10A N.C.A.C. 44; *see also* North Carolina Office of the Chief Medical Examiner (OCME) Guidelines (available at www.ocme.dhhs.nc.gov/rules/guidelines.shtml).

117. G.S. 130A-378.

local medical examiner. The CME or a member of his or her staff reviews each case investigated by a county medical examiner and is authorized to amend death certificates filed by the local examiners.¹¹⁸

For each county, the CME appoints one or more individuals to serve three-year terms as county medical examiners. In making appointments, the CME must give preference to licensed physicians, but he or she may also appoint licensed physician assistants, nurse practitioners, nurses, coroners, or emergency medical technician paramedics.¹¹⁹ Deaths within the medical examiner's jurisdiction include those that

- result from violence, poisoning, accident, suicide, or homicide;
- occur suddenly when the deceased had been in apparent good health or when unattended by a physician;
- occur in a jail, prison, or correctional institution or in police custody;
- occur in state-operated psychiatric hospitals, substance abuse facilities, and certain other state facilities that provide services to individuals with developmental disabilities;
- are the result of an execution carried out under the state's death penalty laws; or
- occur under any suspicious, unusual or unnatural circumstance.

Such deaths are typically reported to the county medical examiner by health care providers or law enforcement, but the law requires anyone who suspects that a death may fall in one of the above categories to report it.¹²⁰ The county medical examiner's duty to investigate is triggered by the receipt of the report. Each county must provide or contract for a facility for the examination and storage of bodies subject to medical examiner jurisdiction.¹²¹

To facilitate death investigations, state laws authorize county medical examiners to inspect physical evidence and documents, including confidential medical records. The medical examiner may seek an administrative search warrant or issue subpoenas for information as the case requires.¹²² A medical examiner may order an autopsy if he or she determines that it would be "advisable and in the public interest."¹²³ A district attorney or a superior court judge may also authorize an autopsy in a medical examiner case.¹²⁴ If a question about a death arises after the body has been buried, the CME may authorize an investigation of the death. In such a case, the district attorney petitions a superior court judge to order the body exhumed and turned over to the CME for investigation.¹²⁵

Upon completion of an investigation, the county medical examiner must complete a certificate of death that states the cause and manner of death. The cause of death is the illness or injury that resulted in death, while the manner of death refers to the medical examiner's conclusion about whether the cause was natural, an accident, suicide, homicide, or undetermined. The county medical examiner must make a full report of the investigation to the CME.¹²⁶ The county medical examiner receives a fee of \$100 for each completed investigation and report. If the deceased was a resident of the county in which the investigation occurred, the fee is paid by the county; otherwise, the state pays the fee.¹²⁷

118. G.S. 130A-382.

119. *Id.* In the past, nonphysician medical examiners were called "acting medical examiners," but this term was deleted from the statute by S.L. 2014-100 (Appropriations Act), sec. 126E.6(a).

120. G.S. 130A-383. In addition, a person who discovers a deceased body or anatomical material that may be part of a human body must report the discovery to the county medical examiner.

121. G.S. 130A-381.

122. G.S. 130A-385 (authority to inspect physical evidence and records and to seek an administrative search warrant); 130A-386 (authority to issue subpoenas for the appearance of persons or production of documents).

123. G.S. 130A-389.

124. *Id.* The North Carolina OCME guidelines specify the types of deaths that require autopsy. There is a fee of \$1,250 for each autopsy. If the deceased was a resident of the county in which the investigation occurred, the fee is paid by the county; otherwise, the state pays the fee. If the medical examiner determines that an autopsy is not necessary but the deceased's next of kin requests it, the CME or a designated pathologist may perform an autopsy and the fee is paid by the next of kin.

125. G.S. 130A-390. The cost of the exhumation, autopsy, transportation, and disposition of the body is paid by the county if the deceased was a resident of the county in which the death or fatal injury occurred; otherwise, the state pays those costs.

126. G.S. 130A-385 (investigation reports); 130A-389 (autopsy reports).

127. G.S. 130A-387.

Some North Carolina counties retain the elected office of county coroner, whose duty is to conduct inquests and preliminary hearings into deaths that may have resulted from criminal acts or omissions.¹²⁸ In counties with coroners, the county medical examiner must notify the coroner of deaths within the medical examiner's jurisdiction, and the coroner must hold an inquest and file a report with the district attorney and the county medical examiner. However, the medical examiner retains custody and control of the body. He or she also retains the ultimate duty and authority to conduct the medico-legal examination of deaths and file the reports required by law.¹²⁹

Vital Records Program

The North Carolina Vital Records Program is responsible for registering vital events that occur in North Carolina. The vital events registered through the program are births, deaths, fetal deaths, marriages, and divorces. The state program is administered by the North Carolina Department of Health and Human Services, Division of Public Health.¹³⁰ At the local level, county registers of deeds and local health departments have extensive duties related to vital records, and clerks of court have a role in the system as well. Private individuals and entities also play a significant role in the vital records system. For example, hospitals and other birthing facilities file birth certificates with local registrars, and funeral directors file death certificates.

The state secretary of health and human services appoints a state registrar to lead the state program.¹³¹ Each county has a local registrar of vital records and a deputy registrar. Some counties also have sub-registrars.

The state registrar's ultimate duty is to ensure that records of vital events are completed accurately and registered. To that end, the state registrar's statutory duties include examining vital records received from local registrars to ensure their satisfactory completion, preserving vital records permanently and in a systematic fashion, and enforcing the state's vital records laws and rules. The state registrar also supervises local registrars, deputy registrars, and sub-registrars.¹³²

By law, the local health director serves as the local registrar for each county within the local health department's jurisdiction.¹³³ He or she must designate in writing a deputy registrar to assist with the local registrar's duties and to act as local registrar in the event of the health director's absence, illness or disability, or removal from office. The local registrar may also appoint one or more sub-registrars with the approval of the state registrar. Sub-registrars are authorized to receive certificates and issue burial-transit permits and are supervised by the state registrar.¹³⁴

The local registrar's duties include

- registering vital events that occur in the county,
- furnishing certificate forms provided by the state registrar to persons who require them and examining certificates that are submitted to assure their satisfactory completion,
- transmitting a copy of each birth or death certificate to the county register of deeds within seven days of receipt,
- sending original certificates to the state registrar, and
- maintaining records and making reports as required by the state registrar.¹³⁵

The county is responsible for ensuring that the local health department has sufficient staff, funds, and other resources necessary to administer the vital records program.¹³⁶

128. G.S. Chapter 152 creates the office of county coroner and prescribes the duties of the office.

129. G.S. 130A-394.

130. G.S. 130A-90, 10A N.C.A.C. 41H .0101. The statute requires the state to maintain a vital statistics program. Regulatory definitions clarify that the terms "vital statistics" and "vital records" mean the same thing: "'Vital statistics' or 'vital records' means records of birth, death, fetal death, marriage, divorce, and data related thereto." 10A N.C.A.C. 41H .0102.

131. G.S. 130A-91.

132. G.S. 130A-92.

133. G.S. 130A-94.

134. G.S. 130A-96.

135. G.S. 130A-97.

136. G.S. 130A-98.

County registers of deeds are a significant component of the vital record system and have numerous legal duties associated with it, including

- filing and preserving copies of birth and death certificates furnished by the local registrar,
- making and keeping an index of certificates,
- keeping certificates open to inspection and examination, and
- providing copies or abstracts to persons who request them.¹³⁷

Clerks of court play an important role in the vital records program as well. The clerk of court with jurisdiction must report divorces and annulments of marriages to the state registrar¹³⁸ and must notify the state registrar of judgments determining the paternity of a child.¹³⁹ The clerk of superior court also has a role in establishing the fact of birth by persons without birth certificates.¹⁴⁰

The vital records program activity that is most visible to the public is the provision of certificates that prove the occurrence of vital events. Certificates of vital events may be obtained from either the state vital records office¹⁴¹ or a local official. Locally, county registers of deeds provide certificates of births, deaths, or marriages.¹⁴² (However, birth certificates for an adopted child must be obtained from the state office.) Certificates of divorce may be obtained from the clerk of court in the county where the divorce was filed.

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- UNC School of Government. *Comparing North Carolina's Local Public Health Agencies: The Legal Landscape, the Perspectives, and the Numbers* (May 2013). www.sog.unc.edu/node/3551.

137. G.S. 130A-99. Under this statute, copies of certificates maintained by registers of deeds must be open to inspection and *uncertified* copies or abstracts of the certificates must be provided to any person on request. However, the provision of *certified* copies of vital records is restricted. G.S. 130A-93(c). For more information about obtaining certified copies of vital records, see <http://vitalrecords.nc.gov/faqs.htm> or contact the county register of deeds. While the copies of certificates that are available in the offices of registers of deeds are open to inspection, only the state registrar may have access to original vital records. G.S. 130A-93. In addition, birth certificates filed with a local health department contain additional medical information that is not open to inspection. G.S. 130A-102.

138. G.S. 130A-111.

139. G.S. 130A-119.

140. G.S. 130A-106.

141. See <http://vitalrecords.nc.gov/>.

142. In Mecklenburg County, certificates of births or deaths that occurred in the county are obtained from the local health department. See <http://charmeck.org/MECKLENBURG/COUNTY/HEALTHDEPARTMENT/Pages/Default.aspx>.

Additional Resources

Websites

School of Government, North Carolina Public Health Systems Research: www.sog.unc.edu/node/2115.

School of Government, North Carolina Public Health Law: www.sog.unc.edu/programs/ncphl.

North Carolina Division of Public Health: <http://publichealth.nc.gov/>.

North Carolina Local Health Department Accreditation: <http://nciph.sph.unc.edu/accred/>.

North Carolina Public Health Incubator Collaboratives: <http://nciph.sph.unc.edu/incubator/>.

Reports, Articles, and Journals

School of Government, Health Law Bulletin Series. <http://shopping.netsuite.com/s.nl/c.433425/sc.7/category.49/f>.

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About the Author

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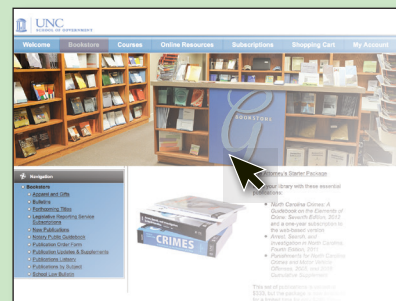
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