Comparing North Carolina's Local Public Health Agencies: The Legal Landscape, the Perspectives, and the Numbers

FINAL REPORT

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UNC SCHOOL OF GOVERNMENT

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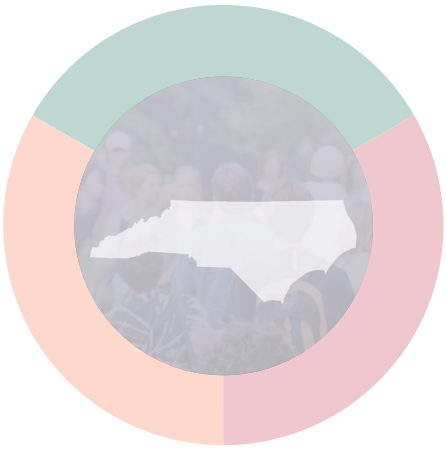

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UNC SCHOOL OF GOVERNMENT

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Support for this research project was provided by a grant from the Robert Wood Johnson Foundation.

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About the Project

In early 2011, UNC School of Government (SOG) faculty members Jill Moore and Aimee Wall began receiving an unusually large number of inquiries about North Carolina's local public health agencies, prompted by several bills under consideration by the General Assembly.

The inquiries included a mix of legal and practical questions. Those who sought the SOG's assistance were interested in the changes the proposed legislation would make to the state's public health laws, but they also wanted to know how the different types of agencies in operation across the state compared with one another on measures such as staffing, costs, public health service delivery, and health outcomes in the communities served by the agencies. The importance of these questions prompted Professors Moore and Wall to collaborate with their colleague Maureen Berner, a SOG faculty member with expertise in program evaluation, to submit a grant proposal to the Robert Wood Johnson Foundation to study local public health services in North Carolina. The proposal was funded and the grant period began in December 2011.

At the time the grant was awarded, the General Assembly was considering several legislative proposals, but it had not yet taken action. The team recognized that it needed to act quickly if it expected to contribute meaningful research to the ongoing policy discussions. The team conducted legal, qualitative, and quantitative research and generated the first version of this report shortly before the General Assembly reconvened for its short session in May 2012. Legislation was enacted in June 2012. This final version of the report includes a revised version of the legal analysis that reflects the changes enacted in 2012 as well as some updates to the quantitative data. Like the preliminary report, this final report does not offer recommendations, best practices, or other endorsements related to the different types of agencies. Rather, the goal is to provide objective, methodologically sound research findings that will support state and local policymakers in their decision-making processes.

Jill D. Moore, MPH, JD, and Maureen Berner, PhD, were the Principal Investigators and Aimee N. Wall, JD, MPH managed the overall project. Moore coordinated the legal analysis and Berner led the comparative evaluation. Moore's team on the legal analysis included Neil Dermody, JD, MPA; Chris Hoke, JD, with the N.C. Division of Public Health; Gene Matthews, JD, with the N.C. Institute for Public Health and the Network for Public Health Law; Drake Maynard, JD; and Wall. Berner's team on the evaluation component included Lydian Altman, MPA; Dayne Batten, MPA; David Brown, MPP; Johanna Foster, MPA; Margaret Henderson, MPA; Milissa Markiewicz, MPH, MIA, from the N.C. Institute for Public Health and the Network for Public Health Law; and Tonya Walton, MPA.

All of the research findings and additional information are available online at www.ncphagencies.unc.edu.

Executive Summary

North Carolina counties are required by law to provide public health services to their residents. State and local policymakers and public health officials share an interest in providing those services in a manner that is efficient, effective, and responsive to local needs. Over time, different ways of providing public health services have been incorporated into the state laws that define various types of local public health agencies and governance structures.

For many years, state and local policymakers, public health practitioners, and others have discussed options for organizing North Carolina's local public health system. In 2011, the conversation was reignited when several bills designed to alter the legal and policy landscape for local public health agencies were introduced in the state legislature.

At the time of this policy debate, comprehensive information about the state's existing local public health agencies did not exist. With funding support from the Robert Wood Johnson Foundation, our research team conducted a comprehensive analysis of public health laws in North Carolina, interviewed more than sixty state and local stakeholders, and compared local public health agencies across a variety of quantitative measures. We presented our findings in a report released in May 2012.

Legislation enacted in June 2012 made several changes to the laws related to the organization and governance of local public health agencies. In this final report, we provide updated summaries of the law as well as more recent quantitative data in some areas. We have not updated the qualitative data in the section entitled "The Perspectives," but we have reprinted most of that section because its findings are still relevant to ongoing policy discussions at the local level. The key findings of our research are presented below.

The Legal Landscape

Local Public Health in North Carolina

Key Findings

- Each county must assure that public health services are available within the jurisdiction.
- Each county has options for its type of local public health agency. Any county may operate a county health department, join a multi-county district health department, or participate in a public health authority. Counties with a county manager may form a consolidated human services agency and provide public health services through it. One county is subject to a unique law that allows it to provide public health services through a public hospital authority.

- The law defines core components of these agencies, such as the composition and role of the governing board; the qualifications, powers, and duties of the director; and the services the agency must provide.
- There are important differences between the types of agencies with respect to budget and finance, boards, appointment of directors, director qualifications, and personnel policies.
    - **Budget and finance.** District health departments and public health authorities have more independence from county government than county health departments and consolidated human services agencies.
    - **Boards.** The local agencies' governing boards have different composition requirements, powers, and duties.
    - **Appointment of directors.** In a consolidated human services agency, the county manager appoints the agency director with the advice and consent of the agency's governing board. In the other types of agencies, the governing board appoints the director after consulting with county commissioners.
    - **Director qualifications.** Directors of county health departments, district health departments, and public health authorities must meet minimum education and experience requirements set forth in state laws. There are no similar requirements for a director of a consolidated human services agency. However, if the director of a consolidated agency does not meet the requirements, he or she must appoint someone who does.
    - **Personnel policies.** Employees of county and district health departments are covered by the State Personnel Act. Employees of a consolidated human services agency are subject to county personnel ordinances and policies unless the board of county commissioners affirmatively elects to place the employees under the State Personnel Act. Public health authorities are also exempt from the State Personnel Act and may establish their own salary plans and policies.
- In practice, counties approach implementation of these agency types in different ways. For example, a county health department may adopt some characteristics of a consolidated human services agency or have a formal or informal agreement with a neighboring county that falls short of creating a district health department.

The Perspectives

What Stakeholders Say

Key Findings

- Local stakeholders observed that all agency types have potential benefits and challenges and want to be able to choose the type of agency that best suits their community.
- Stakeholders stressed the importance of strong leadership in making any type of local public health agency succeed.

- Stakeholders emphasized that when public health practitioners, county administrators, and local elected officials understand one another and work well together, the agency will be stronger regardless of agency type.
- Some county officials (managers, assistant managers, commissioners) voiced support for a system that provides a more active role for county administration in public health management and governance.
- All public health practitioners and many county officials voiced support for the role of an appointed board of health in public health governance.
- While some stakeholders are concerned that if they join a district, the county's sense of ownership of and funding for public health might diminish, others view joining a district as a way to save money.
- Stakeholders use the term "consolidated human services agency" in different ways.
- Stakeholders offered contrasting views on whether there is overlap in the work and clients of public health, social services, and mental health.

The Numbers

Comparison of Agency Types

Key Findings

- Source of funding appears to be associated with agency type. County health departments and consolidated human services agencies tend to receive a larger percentage of their funding from county appropriations than districts and authorities, which receive a comparatively larger percentage of funding from other sources, such as fees for services.
- Regardless of agency type, as the size of the population served increases, both total expenditures per capita and FTEs per 1,000 population tend to decrease.
- While this research is focused on comparing the different types of agencies, it is important to note that the data indicate that there is as much variation *within* types of agencies as *between* types of agencies for most measures examined.
- Agency type does not appear to be associated with
  - use of mobile technology,
  - ability to supplement or replace state-provided software, or
  - number of public health services provided.

Conclusion

When this research project began, North Carolina already had many different types of local public health agencies in operation across the state. When legislation related to the organization and governance of these agencies was enacted in June 2012, the local public health landscape began to shift almost immediately. Several counties abolished local boards of health or established consolidated human services boards. Several counties consolidated public health with other county departments, primarily departments of

social services. Several more counties are planning to implement a change soon or are considering their options for change.

This research provides an important baseline for state and local policymakers as they evaluate the impact of all of these changes in the years to come. Future researchers may want to build on our research to answer questions, such as:

- Have the financial profiles of the newly consolidated human services agencies changed?
- Are counties contributing more or less money to support the agencies?
- How have the workforces of the newly consolidated agencies changed?
- Are the newly consolidated agencies offering more or fewer public health services?
- How have governance changes affected the work of the agencies?
- Have perceptions about the types of agencies shifted as more counties transition to consolidated human services agencies?
- Have new district (regional) health departments been established? If so, how did the change affect the participating counties?

Although the project funded by the Robert Wood Johnson Foundation is complete, we expect to continue to track legislative developments and policy choices at the local level. If we are able to secure additional support in the coming years, we may also try to update some of the data and answer some of these questions or others that emerge. As with all of our research in this evolving area, we will post any updates online at www.ncphagencies.unc.edu.

Part 1. Introduction

"Some realistic information on the different models [would be helpful] . . . What counties are using it? How are they benefitting? Pitfalls and so forth, because right now, we're just talking in a vacuum."
County Commissioner

In North Carolina, there are multiple types of local public health agencies in operation across the state. Some counties stand alone, while some work regionally. Some counties have taken steps to have public health and social services co-locate, coordinate service delivery, or consolidate into a single agency. Some counties have created independent authorities for public health. In some counties, the boards of county commissioners, rather than appointed boards of health, are serving as the governing board for the public health agency. The primary goal of this research project was to collect and disseminate information about the different types of local public health agencies in order to help inform policy discussions at both the state and local levels related to the organization and governance of these agencies.

We gathered information to compare the types of agencies across three broad categories:

- **The Legal Landscape.** In the first section of the report, we provide the background necessary to understand the legal and policy landscape for the delivery of public health services at the local level. We offer answers to questions about the laws that apply as well as some insight into how the agencies operate.
- **The Perspectives.** The second section explores local and state policymakers' and public health leaders' subjective impressions of the different types of agencies. These impressions are a large part of what fuels discussions surrounding change at the local level.
- **The Numbers.** In the final section, we analyze quantitative data to compare the different types of public health agencies in four key areas: financing, workforce, information technology, and services delivered.

In addition to the information included in this report, supplementary materials are available online. For example, our website includes detailed questions and answers about each of the different types of local public health agencies, the directors, and the governing boards. The website also includes a detailed compilation of the perspectives summarized in the report as well as the raw data used in the comparative quantitative analyses. This additional information can be found at www.ncphagencies.unc.edu.

Part 2. The Legal Landscape: Local Public Health in North Carolina

Questions

- Background
  - What did we want to learn?
  - How did we gather information?
- The Public Health System
  - Why does North Carolina have a public health system and local public health agencies?
  - What types of services do local public health agencies provide?
  - Are local public health agencies required to have certain categories of staff or to organize their workforces in particular ways?
  - How are local public health services financed?
- Describing and Comparing Agency Types
  - What types of local public health agencies presently exist in North Carolina?
  - What is a consolidated human services agency?
  - Do the legal definitions of agency types offer the complete picture of how local governments provide public health services?
  - May a county change the type of local public health agency it participates in or operates?
  - How are the different types of local public health agencies similar?
  - What are the key legal differences between the types of local public health agencies?
  - What role do county commissioners play in the creation and operation of local public health agencies?
  - May county commissioners directly assume the duties of local boards of health? If so, what duties would they assume?

Key Findings

- Each county must assure that public health services are available within the jurisdiction.
- Each county has options for its type of local public health agency. Any county may operate a county health department, join a multi-county district health department, or participate in a public health authority. Counties with a county manager may form a consolidated human services agency and provide public health services through it. One county is subject to a unique law that allows it to provide public health services through a public hospital authority.
- The law defines core components of these agencies, such as the composition and role of the governing board; the qualifications, powers, and duties of the director; and the services the agency must provide.
- There are important differences between the types of agencies with respect to budget and finance, boards, appointment of directors, director qualifications, and personnel policies.
    - **Budget and finance.** District health departments and public health authorities have more independence from county government than county health departments and consolidated human services agencies.
    - **Boards.** The local agencies' governing boards have different composition requirements, powers, and duties.
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    - **Director qualifications.** Directors of county health departments, district health departments, and public health authorities must meet minimum education and experience requirements set forth in state laws. There are no similar requirements for a director of a consolidated human services agency. However, if the director of a consolidated agency does not meet the requirements, he or she must appoint someone who does.
    - **Personnel policies.** Employees of county and district health departments are covered by the State Personnel Act. Employees of a consolidated human services agency are subject to county personnel ordinances and policies unless the board of county commissioners affirmatively elects to place the employees under the State Personnel Act. Public health authorities are also exempt from the State Personnel Act and may establish their own salary plans and policies.
- In practice, counties approach implementation of these agency types in different ways. For example, a county health department may adopt some characteristics of a consolidated human services agency or have a formal or informal agreement with a neighboring county that falls short of creating a district health department.

Background

What did we want to learn?

There are many different laws, regulations, policies, and practices that work together to help define the parameters of local public health agencies in North Carolina. For this component of the research, we wanted to collect all of the relevant laws, generate comparisons of the laws that govern the different types of agencies, and synthesize our findings. The information reflected in this section is based on state laws in effect in April 2013. It incorporates changes to state law that were adopted by the General Assembly in the summer of 2012. Expanded versions of the answers to the questions below, as well as more detailed information about all of the agency types and key players in the public health system, are available online at www.ncphagencies.unc.edu.

How did we gather information?

Our legal analysis team consisted of experts in public health law, including several individuals with particular expertise in North Carolina's laws. We drew on this expertise to create an initial list of North Carolina statutes and regulations addressing local public health services or agencies. We also identified other state laws that are potentially relevant to the understanding or management of different types of local agencies, such as laws that affect the operation of independent authorities. In May 2012, we published a report that included a section describing these laws in question and answer format.

During the 2011–2012 biennial session of the North Carolina General Assembly, we tracked several bills that proposed changes to local public health infrastructure, and we posted legislative updates and bill summaries on our project website. Legislation was ultimately enacted in June 2012 that changed the options for counties in determining the organization and governance of their local public health agencies. In this final report, we have updated our legal questions and answers to incorporate the 2012 legislation. Some of the background and practice-based information reflected in these narratives is drawn from other non-legal resources, including personal experiences and communications with public health officials over the years.

The Public Health System

Why does North Carolina have a public health system and local public health agencies?

A North Carolina law describes the purpose and mission of the state's public health system. The purpose is "to ensure that all citizens in the State have equal access to essential public health services," and the 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.[1]

This mission and purpose is consistent with the Institute of Medicine's 1988 definition of "public health" as "what we, as a society, do collectively to ensure the conditions in which people can be healthy."[2] The emphasis this definition places on collective action and the conditions that promote good health reveals a distinction between public health and clinical health care: public health is concerned with the health of populations, not just the health status or condition of a particular individual.

Although the mission and purpose of the public health system is set by the state legislature and extends to all residents, most public health activities and services are carried out locally. Under North Carolina law, the legal responsibility for providing local public health services is given to counties. 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, or contracting with the state to provide public health services.[3]

What types of services do local public health agencies provide?

Local public health agencies provide services at both the community and individual levels. 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.[4] 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.[5] The law 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

1. G.S. 130A-1.1.

2. 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.

3. G.S. 130A-34; 130A-45; 153A-77. A state law that authorizes a hospital authority to provide local public health services appears to apply only to Cabarrus County. S.L. 1997-502, sec. 12 ("Any county which, on or prior to July 1, 1997, established a hospital authority board composed of no more than seven members under the provisions of Part B of Article 2 of Chapter 131E of the General Statutes may, by resolution adopted by its board of county commissioners and with the approval of the State Health Director, assign that authority board the powers, duties, and responsibilities to provide public health services as outlined in G.S. 130A-1.1. Thereafter, such authority board shall act as the local board of health for the county together with such additional powers, duties, and authority assigned to it by the board of county commissioners.").

4. G.S. 130A-1.1. This is the same law that describes the purpose and mission of the state's public health system. See note 1 and accompanying text.

5. See www.cdc.gov/nphpsp/essentialServices.html.

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 2.1 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.[6] 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. The 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 local public health agency must satisfactorily perform about 90 percent of the activities in order to obtain or maintain accreditation.[7]

A third law authorizes the N.C. Commission for Public Health to establish standards for the nature and scope of local public health services.[8] 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.[9] 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 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 2.1 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 medical privacy regulations, local public health agencies must develop and maintain numerous forms, notices, and policies and procedures for keeping health information confidential and secure and for honoring individuals' rights regarding their health information.[10]

The North Carolina Department of Health and Human Services (DHHS) conducts a biennial survey of services provided by local public health agencies in North Carolina, which illustrates the range of local public health services 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. See Appendix A for a list of the 127 services that were included in DHHS's survey for fiscal year 2011.

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6. G.S. 130A-34.1.

7. G.S. 130A-34.1 (requiring local health departments to obtain and maintain accreditation); 10A NCAC Ch. 48 (establishing the benchmarks and standards an agency must satisfy to be accredited). The accreditation rules specify the exact number of activities that must be satisfied in each category for the department to be accredited. 10A NCAC 48B .0103(a).

8. G.S. 130A-9.

9. 10A NCAC 46 .0201–.0216.

10. 45 C.F.R. Parts 160 and 164.

Table 2.1. 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

Figure 2.1. Mandated Public Health Services in North Carolina (10A NCAC 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).

Are local public health agencies required to have certain categories of staff or to organize their workforces in particular ways?

Each type of local public health agency must have a director, who exercises legal powers and duties prescribed by law. The directors of county health departments, district health departments, and public health authorities must meet minimum education and experience requirements that are set out in state law. There is no similar education and experience requirement for the director of a consolidated human services agency (CHSA). However, if the director of a CHSA that provides public health services does not meet those qualifications, he or she must appoint a person who does.[11] The generic term "local health director" encompasses all of these individuals, including a CHSA director or designee for a CHSA that provides public health services.

There is also a state regulation that addresses minimum staffing requirements for local public health agencies.[12] It provides that, in addition to meeting accreditation requirements, agencies must employ a health director, a public health nurse, an environmental health specialist, and a secretary. These staff members must be full-time employees, but an agency may share a health director with another agency.

The state's local health department accreditation standards also address staffing, directly and indirectly. One of the standards directs an agency to employ or contract with one or more licensed physicians to serve as medical director.[13] Other portions of the accreditation rules refer to additional categories of agency staff members or to particular types of expertise that the agency must possess or have access to, but they do not explicitly require the agency to have staff positions for those categories or expertise.[14]

These minimal legal standards likely do not fully answer the practical question of how many or what types of staff members an agency needs. Instead, it is likely that staffing for local public health agencies is primarily determined by the services that the agencies are required to provide. As described above, there are several different sources of law that apply—the essential public health services law, the mandated services rules, and the accreditation requirements. While these laws do not always address staffing needs, agency management must plan workforce development in such a way that all of the required services can be available in the county. For example, one of the mandated services regulations requires that local public health agencies conduct sanitation inspections of restaurants.[15] Another law provides that the individuals who conduct these inspections must be authorized by the state in that particular field of work.[16] Therefore,

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11. G.S. 130A-40 (county and district health departments); 130A-45.4 (public health authorities); 153A-77(e) (consolidated human services agency).

12. 10A NCAC 46 .0301.

13. 10A NCAC 48B .0901(b)(3). Local public health agencies do not have to satisfy 100 percent of the accreditation activities, so it is often possible for an agency to skip a particular provision and still be accredited. However, this provision is not likely to be skipped. Agencies that provide clinical services often rely on physician extenders and nurses to provide many services. These individuals must be supervised by a licensed physician who issues standing orders and oversees clinical care—the role of a medical director. In some agencies the local health director is a licensed physician and may serve in this role.

14. See, e.g., 10A NCAC 41B .0203 (directing agency to assure that staff have expertise in data management); 41B .0301 (requiring access to and consultation with an epidemiologist); 41B .0701 (referring to unit directors for communicable disease, nursing, and environmental health).

15. 10A NCAC 46 .0213.

16. 15A NCAC 01O .0101.

all local public health agencies must ensure that their workforce includes capacity for these types of sanitation inspections.

Local public health agencies have significant discretion with respect to organizational structure. In the course of this research, we reviewed sixty-eight organizational charts from a mix of agency types. While there are some trends and common features across agency types, there are also interesting variations. Some agencies organize staff by profession (for example, nursing, environmental health), and others organize staff by substantive area (for example, community health, clinical, home health). While county health departments and most district health departments appear to be organized in similar ways, the less common agency types—consolidated human services agencies and authorities—tend to have organizational structures that are uniquely tailored to their services and agency.

How are local public health services financed?

Funds for local public health services come from various sources, but the exact mix of funding varies significantly from one local public health agency to the next. Local public health agencies receive funding from each of the following sources:

- County appropriations (the portion of local taxes dedicated to public health services from the county or counties participating in the local agency)
- Medicaid reimbursements (fees for services and a cost settlement distributed by the state)
- State and federal funds (general aid to counties, state funding to support environmental health, state grants, and federal grants)
- Other revenues

Agencies may also receive funding from other sources, such as grants from private foundations or contracts for services. See "Financing" in Part 4 for a more detailed discussion of the funding sources and an analysis of how the proportion of funding from each source varies by agency type.

In the past, no law directly addressed the level of funding that local governments must provide for local public health services, but the laws requiring local agencies to provide particular services or engage in specific activities may have effectively amounted to an obligation to ensure that funding levels were sufficient for the local agency to comply with those requirements.[17] In 2012, the North Carolina legislature enacted a new maintenance-of-effort requirement for county appropriations to local public health agencies in the future. Effective July 1, 2014, a county must maintain its appropriation to its local public health agency from ad valorem tax receipts at a level equal to the amount appropriated in fiscal year 2010–2011.[18] The amount a county may appropriate from sales tax receipts is not affected by the new requirement. It may be that total

17. Two non-supplant statutes have for many years prohibited counties from reducing local appropriations for particular public health programs as a result of state money increases for those programs. G.S. 130A-4.1 is a non-supplant provision for maternal and child health services and G.S. 130A-4.2 is a non-supplant provision for health promotion programs. These laws are not a large factor in local funding for health departments.

18. G.S. 130A-34.4 (enacted by S.L. 2012-126, sec. 3).

appropriations to local public health agencies continue to be determined at least in part by the need for those agencies to meet their legal obligations to provide public health services and perform public health functions.

All funds received or spent by a local public health agency must be budgeted, disbursed, and accounted for in accordance with the Local Government Budget and Fiscal Control Act.[19] 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 are responsible for performing those functions themselves.

Describing and Comparing Agency Types

What types of local public health agencies presently exist in North Carolina?

North Carolina law defines five types of local public health agencies. Any county may operate a county health department, participate in a multi-county district health department, or establish a public health authority. A county with a county manager appointed pursuant to G.S. 153A-81 may provide public health services through a consolidated human services agency (CHSA). A fifth type—a public hospital authority—is authorized by a law that applies only to Cabarrus County. Each type of agency is captured in the generic term "local health department."[20] Although state law also gives counties the option of contracting with the state to provide public health services rather than operating or participating in a local public health agency, no county does so. 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. The generic term "board of health" refers to all of those.[21] 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.[22]

The mix of local public health agencies in North Carolina is in the process of changing as a result of 2012 legislation that authorized more counties to form CHSAs. The

19. G.S. Ch. 159, Subchapter III, Art. 3.

20. 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.

21. 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).

22. 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.

state law governing CHSAs was changed significantly by legislation enacted in June 2012.[23] Under prior law, the only counties that could create CHSAs were those with populations exceeding 425,000. Further, CHSAs were required to include agencies that provided public health services, 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 human services agencies to incorporate into the CHSA. Table 2.2 shows the number of each type that existed on July 1, 2012, and on April 1, 2013. It is expected that the numbers in the right-hand column will continue to change.

Figures 2.2 and 2.3 demonstrate the changes that have been made in agency type and governing boards since July 2012. Figure 2.2 shows counties by agency and governing board type in fiscal year 2011–2012. Figure 2.3 shows the mix of agency types and governing boards on April 1, 2013.

While these maps provide a general picture of local public health in North Carolina, it is important to recognize that all of the agencies that fall into a particular category are not identical in organization or operation. State laws establish the terms that are used to describe the agencies, mandate governing boards for the agencies that vary somewhat in composition and in powers and duties, identify a lead administrator for each type of agency, and set some minimum standards for the services each agency must provide or ensure. However, state laws do not address every aspect of administration and operation, and there is a considerable amount of variation among agencies as a result. The laws for consolidated human services agencies in particular provide counties with a significant amount of flexibility with regard to organizing, governing, and administering an agency.

What is a consolidated human services agency?

A CHSA combines some or all of a county's human services functions into a single agency. A board of county commissioners may 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." The law specifies that a CHSA may include public health, but it does not require public health to be included. On April 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.[24]

A consolidated human services agency typically is governed by a consolidated human services board. If the CHSA includes public health, the consolidated human services

23. S.L. 2012-126, sec. 1 (amending G.S. 153A-77(b)).

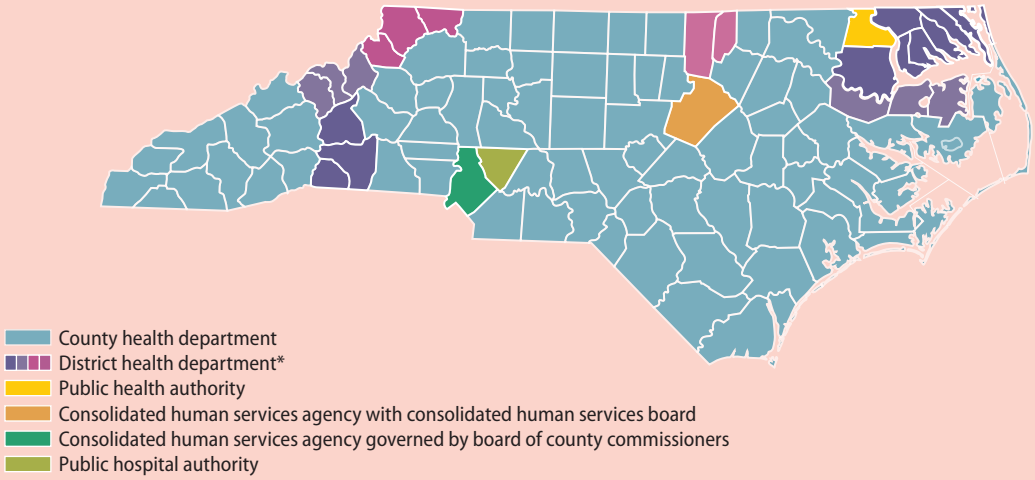
24. G.S. 153A-77(b). There are some limitations to what may be included in a consolidated human services agency. Among other things, G.S. 153A-76 prohibits county commissioners from including a public health authority in a CHSA. However, a separate law permits commissioners to dissolve or withdraw from 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 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.

Table 2.2. Types of Local Public Health Agencies in North Carolina

Type of Agency	Number in North Carolina	
	July 1, 2012	April 1, 2013
County health department	75	68
District health department (multi-county)	6*	6*
Public health authority (single- or multi-county)	1	1
Consolidated human services agency including public health	2	9
Public hospital authority providing local public health services	1	1

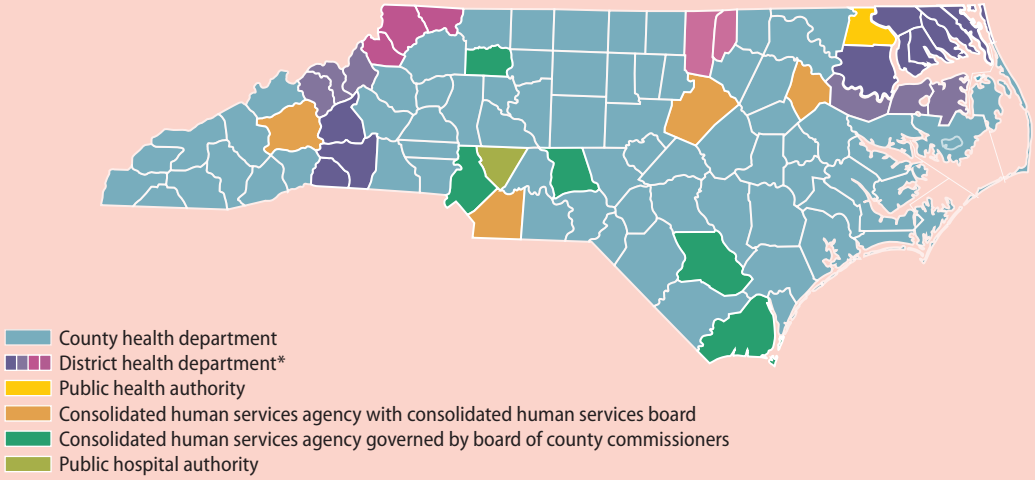
* The six district health departments cover twenty-one North Carolina counties.

Figure 2.2. Types of Local Public Health Agencies and Boards in North Carolina, FY2011–2012



* Shades of pink and purple represent the six different districts.

Figure 2.3. Types of Local Public Health Agencies and Boards in North Carolina, April 1, 2013



* Shades of pink and purple represent the six different districts.

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.[25]

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 state law.[26] The consolidated human services director acquires most of the legal powers and duties of a local health director.[27] The director may exercise those powers and duties directly or may delegate them to the appointee with local health director qualifications or other appropriate persons.[28]

Do the legal definitions of agency types offer the complete picture of how local governments provide public health services?

While the laws may appear to draw clear lines distinguishing between the types of agencies, in practice there is more of a spectrum. Because there are aspects of operations that are within local officials' discretion to manage, local leaders have adopted variations on the different agency types that can blur the distinctions between county health departments and other types of local public health agencies—especially consolidated human services agencies and district health departments. For example, a county health department may

- share administrative staff with a different county agency, such as the department of social services;
- consolidate administrative functions, such as finance or human resources, in a single office housed in county operations rather than in one of the departments;
- co-locate its public health and social services agencies and possibly share front desk and intake operations;
- have an agreement in place with a neighboring county for provision of one or more specific services; or
- have a direct contract in place with staff from a neighboring county for provision of services in off-hours.

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

26. G.S. 153A-77(e)(9) requires the director to appoint an individual "that meets the requirements of G.S. 130A-40(a)"—the state law that sets minimum education and experience requirements for local health directors. 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.

27. G.S. 130A-43(c). However, the director may serve as the CHSA's executive officer only to the extent and in the manner authorized by the county manager, and the director may appoint CHSA staff only with the approval of the county manager. The directors of other types of local public health agencies are subject to direction by their boards rather than the county manager and do not need county manager approval of their hiring decisions.

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

May a county change the type of local public health agency it participates in or operates?

A county may change its agency type if the board of county commissioners approves the decision to change. In some cases the approval of the local board of health is required as well. In order for a county to join a district health department, form a new public health authority, or join an existing public health authority, both the board of county commissioners and the board of health must agree to the change.[29] Other decisions regarding the local public health agency may be made by the board of county commissioners alone. For example, the board of county commissioners may create a consolidated human services agency that includes public health without the local board of health's agreement.[30] County commissioners also may act alone in deciding to dissolve a single-county public health authority, withdraw from a multi-county public health authority, or withdraw from a district health department.[31]

How are the different types of local public health agencies similar?

Each local public health agency in North Carolina has a board, a director, and an agency with staff members who provide public health services at the local level. Each agency is required to be accredited by the North Carolina Local Health Department Accreditation Board.

- **Boards.** The boards governing the agencies serve as the policy-making, rule-making, and adjudicatory bodies for public health within the department's jurisdiction. Each type of board may impose fees for public health services, subject to some conditions.
- **Directors.** Each local agency has a director whose role is defined in part by laws that specify the powers and duties of a local health director.[32] The powers and duties do not vary much by agency type, but there are a few differences that apply to a director of a public health authority or a consolidated human services agency.
- **Services and functions.** Each agency must perform functions and provide services necessary to satisfy accreditation requirements and other laws, such as the North Carolina mandated services rules.

29. G.S. 130A-36 (creation of a district health department); 130A-45.02 (creation of a public health authority).

30. G.S. 153A-77(b).

31. G.S. 130A-45.2 (dissolution of a public health authority); 130A-38 (dissolution of a district health department).

32. The main statute setting forth the powers and duties of local health directors is G.S. 130A-41. See also G.S. 153A-77(e) (consolidated human services directors); 130A-45.5(c) (public health authority directors). However, other powers and duties appear in several other statutes in G.S. Chapter 130A. Some of these additional powers and duties are cross-referenced in G.S. 130A-41, but some are not.

What are the key legal differences between the types of local public health agencies?

There are important differences between the types of agencies in five general areas: budget and finance, boards, appointment of directors, director qualifications, and personnel policies.

- **Budget and finance.** County health departments and consolidated human services agencies are components of county government and are units of the county for many purposes, including finance and budgeting. The budget of a county health department or consolidated human services agency is established by the county it serves, and the county is held accountable for financial management under state law.[33] In contrast, public health authorities and district health departments function as separate entities. They establish their own budgets separate from the county and are directly accountable for compliance with state financial management laws.[34] They may submit budget requests to the county for funding to support their work, but the overall budget remains within their control.
- **Boards.** The boards of the different types of agencies differ, both in powers and duties and in membership. Public health authority boards have expanded powers and duties compared to county and district boards of health. Consolidated human services boards have all of the powers of county and district boards of health, except that a consolidated human services board does not directly appoint the agency director (who is appointed instead by the county manager, with the board's advice and consent). See Table 2.3 for a summary comparison of the boards' powers and duties. The number of board members may be as few as seven for a public health authority board or as many as twenty-five for a consolidated human services board. The composition of board membership also varies by type of board. See Table 2.4 for a summary comparison of the membership requirements. Finally, in counties with county health departments or consolidated human services agencies, the board of county commissioners may abolish the agency's appointed governing board and directly assume its powers and duties. A board of county commissioners that takes this action must appoint an advisory committee on health that has the same membership as a county board of health.[35]

33. The applicable law is the North Carolina Local Government Budget and Fiscal Control Act, G.S. Chapter 159, Subchapter III, Art. 3.

34. G.S. 130A-36(a) (a district health department is a public authority as defined in the Local Government Budget and Fiscal Control Act and thus subject to that act); 130A-45.02(g) (a public health authority is a public authority as defined in the Local Government Budget and Fiscal Control Act and thus subject to that act).

35. G.S. 153A-77(a). It is possible for a board of commissioners to assume the powers and duties of a board of health for a county with a district health department or a public health authority, but the commissioners must first dissolve or withdraw from the district or authority, an action that may be taken only at the end of a fiscal year. G.S. 130A-38 (district health department); 130A-45.2 (public health authority). After dissolving the district or authority, the commissioners could create either a county health department or a consolidated human services agency to provide public health services within the jurisdiction and then assume the powers and duties of the agency's board.

Table 2.3. Comparison of Powers and Duties by Type of Board

	County Board of Health	District Board of Health	Public Health Authority Board	Consolidated Human Services Board
Adopt local public health rules	Yes	Yes	Yes	Yes
Make policy for the local agency	Yes	Yes	Yes	Yes
Adjudicate appeals related to local rules or fines imposed by the local health director	Yes	Yes	Yes	Yes
Appoint local health director after consultation with board (or boards) of county commissioners	Yes	Yes	Yes	No, county manager appoints human services director with consent of the board
Impose fees for services	Yes, subject to approval of BOCC[a]	Yes, subject to approval of all BOCCs[a]	Yes	Yes, subject to approval of BOCC[a]
Prepare and recommend the agency budget	Informal role[b]	Yes	Yes	Yes[c]
Approve local public health agency budget	No	Yes	Yes	No
Enter contracts[d]	No	No	Yes	No
Set salaries of employees and professional reimbursement policies	No	Yes, with approval of Office of State Personnel[e]	Yes	No
Employ legal counsel and staff	No	Yes	Yes	No
Construct or otherwise acquire property for use as public health facilities	No	No	Yes	No
Sell surplus buildings, land, and equipment	No	No	Yes	No
Establish and operate health care networks and contract for the provision of public health services	No	No	Yes	No

a. Fees imposed by a county, district, or consolidated board must be based on a plan recommended by the health director and approved by the board of county commissioners.
b. It is customary for a county board of health to develop a proposed budget for the county health department.
c. Consolidated human services agency boards plan and recommend the agency's budget (G.S. 153A-77(d)(7)) but are prohibited from transmitting or presenting the budget for local health programs (G.S. 130A-43(b)(2)) and do not approve the final budget.
d. County, district, and consolidated boards do not have the authority to enter contracts. A separate statute authorizes local health directors to enter contracts on behalf of the local health department; however, the director's authority may not be construed to abrogate the authority of the county commissioners.
e. The salaries of district health department employees are based on a plan that the district board of health adopts, but the plan must be approved by the Office of State Personnel.

- **Appointment of directors.** The appointment of the local health director is managed differently by the different types of agencies:
  - In county and district health departments, the director is appointed by the local board of health after consultation with all applicable boards of county commissioners.

Table 2.4. Comparison of Board Membership Requirements by Type of 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.

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.

- In a public health authority, the authority board appoints the director after consultation with all applicable boards of county commissioners.
- In a consolidated human services agency, the agency director is appointed by the county manager with the advice and consent of the consolidated human services board. The agency director then appoints a person who meets the statutory qualifications of a local health director, with the approval of the county manager.

- If the county commissioners have abolished the board of health pursuant to G.S. 153A-77(a), then the commissioners have all the powers and duties of the local board of health. For a county health department, this includes the power to appoint the local health director. For a consolidated human services agency, this includes the power to advise and consent to the county manager's appointment of the consolidated human services director.

- **Director qualifications.** The directors of county health departments, district health departments, and public health authorities must meet minimum education and experience requirements set forth in state laws, which generally require a background in medicine, public health, or public administration related to health services. There is no similar education and experience requirement for the director of a consolidated human services agency. However, if the director of a CHSA that provides public health services does not meet those qualifications, he or she must appoint a person who does.[36] 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.[37]
- **Personnel policies.** The employees of county and district health departments are covered by the State Personnel Act.[38] Public health authorities are exempt from the State Personnel Act and establish their own personnel policies and salary plans.[39] The employees of consolidated human services agencies are subject to county personnel policies or ordinances unless the board of county commissioners affirmatively elects to make the CHSA employees subject to the State Personnel Act.[40] The directors of all of the different types of local public health agencies may appoint employees, but appointments made by a director of a consolidated human services agency must be approved by the county manager. The directors of the other types of departments are not required to obtain the county manager's approval before appointing employees.

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36. G.S. 130A-40 (directors of county and district health departments); 130A-45.4 (public health authority director); 153A-77(e) (consolidated human services agency).

37. See 10A NCAC 48B .1304; see also 10A NCAC 48B .0901(b)(1) (requiring the agency to have, or to be recruiting, a local health director who meets legal requirements for the position). The accreditation program does not require local agencies to satisfy every provision in the standards—agencies may skip a small proportion of the standards and still be accredited. Therefore, it is possible that a consolidated agency could satisfy *accreditation* standards without meeting the specific standard that addresses the director's qualifications. 10A NCAC 48B .0103. The statutory requirement for a person meeting these qualifications would still apply.

38. G.S. 126-5(a)(2).

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

40. G.S. 153A-77(d). If a county that has a consolidated human services agency withdraws its employees from the State Personnel Act, the county personnel policy or ordinance must comply with the applicable federal merit personnel standards found in 5 C.F.R. Subpart F. G.S. 153A-77(d).

What role do county commissioners play in the creation and operation of local public health agencies?

North Carolina law requires counties to provide public health services to their residents. County commissioners take several actions to ensure that this happens:

- **Selection of agency type.** Commissioners are key players in the selection of the type of local public health agency. The commissioners alone may choose to operate a county health department or to provide public health services through a consolidated human services agency. The commissioners may jointly resolve with the local board of health to join a district health department or form a public health authority.
- **Appointment of board.** County commissioners make appointments to the local public health board. The board of county commissioners appoints all the members of a county board of health, a single-county public health authority board, or a consolidated human services board. The boards of district health departments or multi-county public health authorities are appointed somewhat differently: the board of county commissioners of each participating county appoints one county commissioner to the health board, and then those commissioners appoint all the remaining members. Finally, the county commissioners may serve as the local board of health by adopting a resolution assuming the powers and duties of the county board of health or county consolidated human services board.[41] When a board of county commissioners takes this action, it must appoint an advisory committee on health that has the same membership as a county board of health (see Table 2.4).
- **Approval of budget or budget request.** County commissioners approve the budgets of local public health agencies that are county departments (either a county health department or a consolidated human services agency that includes public health). If the county participates in a public health authority or district health department, the commissioners are involved in approving budget requests or providing funding to the agency. Effective July 1, 2014, county appropriations to the local public health agency from ad valorem tax receipts must match the amount provided from those receipts in state fiscal year 2010–2011.[42]

41. A board of county commissioners that wishes to directly assume the powers and duties of its county board of health or consolidated human services board must first hold a public hearing. Thirty days' notice of the hearing must be published in a newspaper with general circulation in the county. G.S. 153A-77(a).

42. G.S. 130A-34.4. This maintenance-of-effort requirement applies to all agency types and is a condition that must be satisfied for the local agency to continue to receive state and federal funds after July 1, 2014.

May county commissioners directly assume the duties of local boards of health? If so, what duties would they assume?

State law permits boards of county commissioners to abolish any or all of their local human services boards and directly assume the powers and duties of the abolished boards. The law that permits this applies to boards that are either (1) appointed by the commissioners, or (2) acting under the commissioners' authority.[43] Boards of commissioners may abolish and assume the duties of a county board of health or a consolidated human services board. Commissioners are expressly prohibited from abolishing and assuming the powers and duties of a public health authority board, even though such boards are appointed by the commissioners.[44]

A board of county commissioners may not use this authority to abolish the board of a district health department or a multi-county public health authority, because the commissioners appoint only a subset of those boards' members, the agencies represent multiple counties, and the agencies operate pursuant to their own legal authority (rather than the county's). The board of county commissioners may, however, withdraw its county from a multi-county arrangement.

If a board of county commissioners abolishes its local health board, the commissioners acquire the following powers and duties related to public health and the operation of the local public health agency:

- **Role and charge.** A local board of health is responsible for protecting and promoting the public's health within its jurisdiction.[45] A board of county commissioners that assumes the board of health's powers and duties acquires this responsibility.
- **Appointment of the local health director.** A county board of health appoints a local health director after consultation with the county commissioners.[46] If the county commissioners abolish the county board of health and assume its duties, the commissioners are responsible for appointing the local health director. A consolidated human services board does not directly appoint the agency director, who is instead appointed by the county manager. However, the board must advise the manager and consent to the manager's appointment. The agency director then appoints a person who meets the statutory qualifications of a local health director, with the approval of the county manager.[47]
- **Policy-making authority for the department.** The board of county commissioners becomes the policy-making body for the local public health agency.[48]

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43. G.S. 153A-77(a).

44. G.S. 153A-76(5). This law also prohibits commissioners from abolishing the board of a public hospital authority assigned to provide public health services under S.L. 1997-502, sec. 12—the law that permits Cabarrus County to provide public health services through a public hospital authority.

Another law, G.S. 130A-45.2, authorizes county commissioners to dissolve or withdraw from a public health authority if the commissioners determine that the authority is not acting in the best health interests of the service area. If a board of commissioners takes this action, they need to determine how local public health services will continue to be provided in their county. If they choose to provide services through a county health department or a consolidated human services agency, they may then exercise the option of acting directly as the governing board for the new agency.

45. G.S. 130A-39(a).

46. G.S. 130A-40.

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

48. G.S. 130A-35(a).

- **Rule-making authority for public health throughout the jurisdiction, including within municipalities.** Local boards of health have the authority to adopt rules to protect and promote the public's health within their jurisdictions.[49] The rule-making authority of a local board of health differs from the ordinance-adopting authority of boards of commissioners in significant ways, such as territorial jurisdiction, rule-making procedures, and enforcement options. A board of county commissioners that has assumed the powers and duties of a local board of health therefore needs to determine and document when it is exercising its general ordinance-making authority versus its public health rule-making authority in order to ensure that proper procedures are followed and any limits to the authority are observed.
- **Adjudicatory body for public health.** The board of county commissioners acquires the power and duty to adjudicate disputes pertaining to the local agency's application of local board of health rules or the imposition of administrative penalties by the local health director.[50] For example, if the local health director imposed a fine on a restaurant for failing to comply with the state law governing smoking in public places and the restaurant appealed the fine, the board of county commissioners would hear the appeal and issue a decision.
- **Imposing fees for public health services.** A local board of health has limited authority to impose fees for services rendered by the local public health agency, with the approval of the board of county commissioners.[51] State law prohibits fees for some services.[52] Fees must be deposited into the local agency's account and expended for public health purposes.[53] A board of county commissioners acting as the board of health has the authority to impose these fees, subject to any applicable limitations in state or federal law.
- **Duties related to accreditation.** North Carolina law requires each local public health agency to obtain and maintain accreditation.[54] As part of the accreditation process, the local board of health must satisfy at least twenty-five of twenty-eight activities[55]—a duty the county commissioners acquire. The activities for boards of health include attending specific training, approving policies for the administration of local public health programs, exercising rule-making authority, advocating in the community for public health, and promoting the development of public health partnerships.[56]

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49. G.S. 130A-39(a).

50. The statutes that make the local board of health the adjudicatory body for these issues are G.S. 130A-35(a) (county board of health); 130A-45.1 (public health authority board); and 153A-77(d) (consolidated human services board). Actions that may be adjudicated and procedures for adjudications are in G.S. 130A-24.

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

52. See, e.g., G.S. 130A-130 (testing or counseling for sickle cell disease); 130A-144(e) (diagnosis or treatment of tuberculosis or sexually transmitted diseases); 130A-153(a) (childhood immunizations for families who meet income and other criteria); 10A NCAC 41A .0202(9) (testing and counseling for HIV). Federal laws also prohibit or limit fees for some services. For example, local health departments may not charge clients for language interpretation services. For some programs, fees may be charged only in accordance with sliding scales set by federal regulations.

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

54. G.S. 130A-34.1.

55. 10A NCAC 48B .0103(a)(3).

56. 10A NCAC 48B .1301–.1308.

Part 3. The Perspectives: What the Stakeholders Say

Questions

- Background
  - What did we want to learn?
  - How did we gather information?
- Benefits and Challenges
  - What do stakeholders perceive as the benefits and challenges of the agency types?

Key Findings

- Local stakeholders observed that all agency types have potential benefits and challenges and want to be able to choose the type of agency that best suits their community.
- Stakeholders stressed the importance of strong leadership in making any type of local public health agency succeed.
- Stakeholders emphasized that when public health practitioners, county administrators, and local elected officials understand one another and work well together, the agency will be stronger regardless of agency type.
- Some county officials (managers, assistant managers, commissioners) voiced support for a system that provides a more active role for county administration in public health management and governance.
- All public health practitioners and many county officials voiced support for the role of an appointed board of health in public health governance.
- While some stakeholders are concerned that if they join a district, the county's sense of ownership of and funding for public health might diminish, others view joining a district as a way to save money.
- Stakeholders use the term "consolidated human services agency" in different ways.
- Stakeholders offered contrasting views on whether there is overlap in the work and clients of public health, social services, and mental health.

Background

What did we want to learn?

As discussed in the previous section, North Carolina allows counties to select one of several different agency types for delivering local public health services. Many counties have chosen to retain the traditional county health department model, several have joined with other counties to form district health departments, and some have opted to provide public health services through authorities or consolidated human services agencies. One facet of this research project was to synthesize and compare local policymakers' and public health leaders' subjective impressions of the different types of local public health agencies before the legislation was enacted in June 2012. These impressions reflect the perspectives that fuel some of the discussions about change at the local level.

How did we gather information?

In early 2012, we convened four focus groups and conducted key informant interviews. A total of sixty-four individuals (stakeholders) participated in this component of the study:

- **Four focus groups.** Two groups included randomly selected local health directors and the other two groups included randomly selected county officials (commissioner members of boards of health, county managers, or their designees).
- **Interviews.** Key informant interview subjects included current and former local and state public health practitioners, county managers and assistant county managers, county commissioners, state legislators, representatives from the North Carolina Association of County Commissioners, and representatives from the UNC Gillings School of Global Public Health who work closely with local public health agencies.

This section provides a summary of the information gathered during those focus groups and interviews. It highlights and discusses eight overarching key findings and summarizes stakeholders' impressions of the four agency types. More detailed findings from the focus groups and interviews are included in Appendix B.

Note that all of these conversations occurred *before* the legislation was enacted in June 2012 and *before* counties began changing from one agency type to another. Impressions and opinions of stakeholders may have shifted significantly over the past year.

Discussion of Key Findings

During the focus groups and interviews, several common themes and common messages emerged. We have identified them as "key findings" and offer a brief discussion of each below, along with some selected quotes from stakeholders.

Local stakeholders want to be able to choose the type of agency that best suits their community.

Stakeholders expressed a desire to choose an agency type that is right for their local community. County officials voiced concern about being required by the state to join a district, and public health practitioners voiced concern about being required by boards of county commissioners to form consolidated human services agencies.

"I don't think any of us can really say if we are forced by our board of county commissioners to go into human services agencies what the expectations are going to be and [whether we] are ultimately going to really have a better organization because of the decision to do so."

Local Public Health Practitioner

"I don't think the state should tell us that we have to consolidate or we have to go into a multi-county district. I think there should be a menu and we should have choices. And it should be what fits best for us."

County Commissioner

"Let the local communities make those decisions [about what type of agency to operate]. Don't have it imposed by the state of North Carolina."

Former County Manager

Stakeholders stressed the importance of strong leadership in making any type of local public health agency succeed.

Various stakeholders discussed how an agency's success depends on having a health director who is an effective leader. They also observed that different types of agencies might require different types of leadership. For example, stakeholders reported that district health departments and public health authorities might be best served by individuals who are entrepreneurial and have business management skills, whereas training and experience across disciplines (public health, social services, mental health, integrated service delivery) would likely be needed to successfully lead a consolidated human services agency.

"I don't think the emphasis needs to be on the model, so much as it needs to be on the leadership within those models."

Local Public Health Practitioner

"It all boils down to leadership at the agencies and creating a results orientation."

State Policymaker

Stakeholders emphasized that when public health practitioners, county administrators, and local elected officials understand one another and work well together, the agency will be stronger regardless of agency type.

Stakeholders observed that the relationships among key local leaders are critical to the success of any type of local public health agency. They explained that it can be challenging to build these relationships because local leaders have different professional backgrounds, interests, and

"I feel really fortunate . . . to have a county where the system works so well and the employees are so dedicated and work so hard . . . . [I]nstead of trying to find a way to enforce a rule, they find a way they can make a situation work."

County Commissioner

"Everybody hopes for a personality mix [health director, county manager, commissioners, and board of health] that works by and large, and that can overcome a lot of challenges and overcome a lot of problems and a lot of shortcomings, organizational difficulties."

Local Public Health Practitioner

"If we [public health practitioners] could . . . maintain a closer working relationship with our elected officials, seeing where they're getting pressures . . . find better ways to talk to them so we can get after problems when they're just in their infancy and work with commissioners to resolve them . . . I think that would be most helpful."

Former Local Public Health Practitioner

"Relationships are everything. Everything."

Local Public Health Practitioner

"The county manager should have the authority, for lack of a better word, to insert him or herself into the operation if he or she sees something that is not serving the community well. . . . We don't really have an effective tool to make the changes that we think drive the right efficiencies in the organization, that build the right organizational structure, that put the focus on the right things."

Assistant County Manager

"I think this whole thing comes down to a difference in philosophy. Should people who are spending our government money providing government services, should they be directly answerable to the public?"

State Policymaker

"[Boards of health] have operated traditionally, predominantly, if not totally, on the basis of good science . . . and have resisted any kind of political interference in their work, in their decisions, in their rule-making."

Former State Public Health Practitioner

"We like the governance structure, the fact that there are certain mandated positions, so having the doctor and dentist and so forth gives a good representative base of expertise. And I think the other thing too that works for us is that there's a high level of accountability because we've got folks that live in the community that serve on the public health board."

County Commissioner

"I think that there should be a place for a group of professional health officials to serve as an advisor to a county commission. I think that's a critical role . . . but in the end I think those policy choices ought to be chosen by the county commission[ers]."

Assistant County Manager

focus. Stakeholders emphasized, however, that if local leaders are able to understand one another and align their goals, the agency—regardless of type—has a much better opportunity to succeed.

Some county officials voiced support for a system that provides a more active role for county administration in public health management and governance.

Some county officials (managers, assistant managers, commissioners) reported that accountability and transparency could be increased if local public health agencies were more like other county departments, with similar lines of authority (health director reports to county manager, who reports to county commissioners; local agency employees are subject to county personnel policies). These stakeholders explained that an enhanced role in public health governance would not only increase accountability and transparency but would also provide county managers with more opportunity to use their expertise in public administration to help guide health department operations.

All public health practitioners and many county officials voiced support for the role of an appointed board of health in public health governance.

Many stakeholders expressed support for a system where public health decision making is a step removed from elected officials in order to avoid the politicization of health policies and rules. These stakeholders stated that, through an appointed board of health (comprising a commissioner, health professionals, and members of the public), health policies can be made on the basis of good science without political bias. These stakeholders expressed some reservations about boards of county commissioners serving as boards of health, stating that commissioners already have full and varied agendas, generally do not have technical expertise in public health, and might be subject to political pressures.

In contrast, a subset of county officials voiced support for a system where the board of county commissioners assumes the duties of the board of health, noting a potential

for greater accountability and faster and more efficient decision making. Some of these stakeholders expressed support for preserving the technical expertise of the board of health in an advisory capacity through the formation of a special committee.

While some stakeholders are concerned that if they join a district, the county's sense of ownership of and funding for public health might diminish, others view joining a district as a way to save money.

Many stakeholders noted that both district health departments and authorities seem to receive a lower percentage of their funding from county appropriations than traditional, single-county health departments. These stakeholders observed that districts and authorities, largely because they have more flexible management systems, appear to be able to bring in additional revenue by providing services (for example, home health, hospice) that is then used to supplement the cost of public health service delivery. While a number of stakeholders viewed this as a strength of those agency types (because the county could save on or control public health costs), others argued that counties in these arrangements might not be paying their fair share.

"Those counties [in a district] don't provide a whole lot of funding, in fact they provide almost no funding at all. . . . [T]here ought to be at least a minimum level of funding."

State Policymaker

"It's important that [the county] fund those services because they are the core services of county government."

Former County Manager

"A single county might be motivated to move to a district model if they can save money, and if they can hold their contribution at current level or even better, back off of it."

Local Public Health Practitioner

"In calling the managers that are part of a regional operation, the per capita cost is actually a little bit less or a lot less when you look at what a single-county agency has to pay to maintain a doctor and the nurses; whereas the overhead from a regional, it's lower per capita. Of course, that's what motivates the county commissioners that have to balance the budget every year as long as the services are being provided."

County Manager

Stakeholders use the term "consolidated human services agency" in different ways.

Stakeholders interpreted and used the term "consolidated human services agency" differently depending on the level of integration they envisioned. Some envisioned minimal integration of different departments while others envisioned a fairly comprehensive integration, including combining administrative functions, cross-training staff, coordinating services, merging boards, and centralizing leadership and management.

When discussing the benefits and challenges of the consolidated human services agency, most public health practitioners seemed to be describing a highly integrated agency. On the other hand, most county officials seemed to be describing an agency that was less integrated.

"[Social services are] primarily providing assistance to individuals and families who are in crisis . . . . [P]ublic health is about policy, it's about prevention, [it's about] assurance."

Former Local Public Health Practitioner

"Prevention, the total population perspective is something that didn't quite fit with mental health [and] social services' mission. They have a very specific mission, very specific population. So when you try to put them all three together it's a tough fit because the missions do not align. And, in fact, they're almost polar opposites with what we're trying to do in terms of preventing problems and engaging the whole population and looking at the quality of life of the entire community versus services for very special populations."

Former State Public Health Practitioner

Stakeholders offered contrasting views on whether there is overlap in the work and clients of public health, social services, and mental health agencies.

Most county officials reported that the clients of local human services agencies, particularly public health and social services, are largely the same. These stakeholders stated that consolidation of human services agencies could therefore reduce duplication of services and save costs. Further, by co-locating agencies and coordinating service delivery, counties could make services more accessible to clients, who are already in difficult life situations.

By contrast, nearly all public health practitioners reported that there is limited overlap among the clients of the three agencies. They observed that where there is overlap, it generally occurs around clinical services. They noted that not all local public health agencies offer clinical services and that those that do may be shifting away from these types of services. Practitioners also emphasized that public health agencies serve the entire population, whereas social services and mental health agencies serve subpopulations. Practitioners further highlighted the different orientations of public health (for example, prevention) and social services and mental health (for example, crisis intervention).

Benefits and Challenges

What do stakeholders perceive as the benefits and challenges of the agency types?

Stakeholders identified benefits and challenges associated with all of the different types of local public health agencies. This section includes five tables that summarize stakeholders' perceptions of the various agency types. We grouped the perceptions into four general categories: finance, workforce, service delivery, and management and governance. The high level summary in Table 3.1 spans across all four types and allows direct comparison of agency types. Tables 3.2 through 3.5 offer a more detailed look at the stakeholders' perceptions of each agency type. Appendix B provides an even more detailed summary of stakeholders' perceptions.

While some stakeholders perceived a feature of a particular agency type as beneficial, others perceived the same feature as a challenge or cause for concern. In many areas, perceptions were closely associated with stakeholders' professional backgrounds. For example, many public health practitioners appeared to be in agreement on some issues, and county officials appeared to be in agreement on others. This was not always the case, however. On several issues, quite a few stakeholders from all professional backgrounds shared perceptions and opinions that were similar.

Table 3.1. Perceptions of Stakeholders: Summary Comparison

	County Health Department (CHD)	District Health Department (DHD)	Public Health Authority (PHA)	Consolidated Human Services Agency (CHSA)
Finance	▪ Potential for greater county investment in public health ▪ Financial investment varies by county; small (low population) counties may struggle to provide adequate resources	▪ Ability to lower county appropriation by bringing in multiple revenue streams that subsidize public health ▪ Dependent on revenue generation	▪ Ability to lower county appropriation by bringing in multiple revenue streams that subsidize public health ▪ Dependent on revenue generation	▪ May be able to save money by combining administrative functions ▪ No hard evidence of cost savings
Workforce	▪ Staff are dedicated to public health ▪ Can be challenging for small counties to recruit and retain staff	▪ Able to retain quality staff, including specialized staff ▪ Requires a health director that is entrepreneurial and has business management skills	▪ Increased flexibility in hiring ▪ Requires a health director that is entrepreneurial and has business management skills	▪ Can cross-train staff and leadership can work together to prioritize use of resources ▪ Requires a leader with training in multiple disciplines
Service Delivery	▪ Responsive to local needs; visible to community ▪ Quantity and quality of services varies from CHD to CHD	▪ Effective way for small counties to provide quality services ▪ Might be challenging to be responsive to local needs	▪ Increased flexibility in providing services and ability to provide services to clients from outside the county ▪ Might raise some fees in ways that hurt customers	▪ Opportunity to coordinate services and eliminate duplication of services ▪ Challenge to coordinate services because of differences in clients, mission, and funding
Management & Governance	▪ BOH provides expertise that helps inform and depoliticize decision making; insulates county commissioners and health department from politically sensitive decisions ▪ BOH is not directly accountable to the public and can be challenging for county manager to become involved in management of health department when a problem is perceived	▪ More flexibility with hiring, contracting, and procurement because of greater autonomy ▪ District board has similar benefits to county BOH, but can be more action-oriented because district board also has financial decision-making authority ▪ Concern that county ownership is reduced and that district could dissolve if counties become unhappy	▪ More flexibility with hiring, contracting, and procurement because of greater autonomy ▪ Concern that local control/input is reduced; governance is separated from elected officials ▪ Challenging to launch an authority; might meet resistance from BOCC, who don't want to give up control, and from employees, who fear leaving the state personnel system	▪ Has lines of authority that are similar to other county departments ▪ Protection against political hiring (provided by State Personnel Act) is lost in CHSA model ▪ Concern about ability of consolidated board (or BOCC) to make effective decisions given the need to know the rules and regulations of public health, social services, and mental health

BOCC: board of county commissioners; BOH: board of health; CHD: county health department; CHSA: consolidated human services agency; DHD: district health department; PHA: public health authority

Table 3.2. Stakeholders' Perceptions of County Health Departments

	Benefits	Challenges/Concerns
Finance	▪ Potential for greater county financial investment in public health	▪ Can be a struggle for small counties to provide adequate resources ▪ County appropriation can be dependent on county officials' commitment to public health; variable from county to county and can vary in a single county over time
Workforce	▪ Staff are dedicated to public health; have a single mission	▪ Can be a challenge for small (low population) counties to attract and retain qualified staff
Service Delivery	▪ Can be responsive to community needs ▪ Public health is "visible" to the community ▪ Can be effective for emergency preparedness; can readily partner with other county level responders	▪ Quality and quantity of services can vary from county to county based on resources, leadership, and local support for public health
Management & Governance	▪ Oversight shared by health director, county manager, BOH, and BOCC ▪ Potential for greater collaboration with other county departments and schools; county manager can work with department heads to create a "county vision of services" ▪ Professional expertise on BOH enables more effective public health policy ▪ Appointed BOH can depoliticize public health decision making ▪ BOH can insulate health director, department employees, and county administration from politically sensitive decisions and policies	▪ Concern that BOH is not directly accountable to the public ▪ Can be difficult to find health professionals to serve on BOH in small counties ▪ Can be challenging for county manager to become involved in management of health department when a problem is perceived ▪ Can be challenging for county manager to have health department employees under a different personnel system than most other county employees

BOCC: board of county commissioners; BOH: board of health

Table 3.3. Stakeholders' Perceptions of District Health Departments

	Benefits	Challenges/Concerns
Finance	▪ County can save money (lower county appropriation) ▪ Can achieve economies of scale by spreading administrative costs over a larger operation ▪ Can bring in multiple revenue streams that can subsidize public health	▪ With lower county appropriation, concern that counties might not have "enough skin in the game" ▪ Dependent on revenue generation; financial viability might be challenged in a location where alternative revenue streams are scarce ▪ Unequal appropriations from different counties could result in dissolution of district
Workforce	▪ Able to attract and retain qualified staff; can pay higher salaries ▪ Able to afford and fully utilize specialized staff	▪ Requires a health director who is entrepreneurial and has business management skills ▪ Challenge for health director to foster an environment where employees view themselves as part of an integrated district
Service Delivery	▪ Effective way for small counties to provide quality services ▪ Can be responsive to differences in local needs by providing specialized services in some counties and core services in all counties	▪ Can be challenging to be responsive to local needs, especially if dissimilar counties (based on resources, demographics, and culture) are mandated into districts ▪ Might be challenging to provide adequate services in an emergency if multiple counties in district are affected
Management & Governance	▪ More flexibility with hiring, contracting, and procurement because of greater autonomy from county ▪ Because of this flexibility, DHD can be a more attractive partner to private and non-profit organizations ▪ District board has same benefits as traditional county BOH; in addition, can be more action-oriented because district board also has financial decision-making authority	▪ Can be challenging for health director to manage multiple sets of relationships (county managers, BOCCs, and others in each county) ▪ Concern that county ownership of public health is reduced ▪ Concern that district BOH might be too large

BOCC: board of county commissioners; BOH: board of health; DHD: district health department

Table 3.4. Stakeholders' Perceptions of Public Health Authorities

	Benefits	Challenges/Concerns
Finance	▪ Can bring in multiple revenue streams that can subsidize public health ▪ Can allow county to control public health costs (e.g., with a fixed per capita appropriation)	▪ County appropriation might be low, similar to a district ▪ County retains responsibility under state law to provide public health services if the public health authority fails ▪ Dependent on revenue generation; financial viability might be challenged in a location where alternative revenue streams are scarce
Workforce	▪ Increased flexibility in hiring; can set own personnel policies	▪ Requires a health director that is entrepreneurial, has business management skills, and is willing to take risks
Service Delivery	▪ Increased flexibility in providing services because of independence from county ▪ Can serve clients from outside of county	▪ Might raise fees in ways that hurt clients
Management & Governance	▪ More flexibility with hiring, contracting, and procurement because of independence from county ▪ Might be more attractive to private and non-profit sector organizations that do not want to partner with a bureaucratic government agency or one that can only provide services in one jurisdiction ▪ Authority board may have more opportunity to adopt policies because it is even more insulated from politics than traditional BOH	▪ Concern that local control/input is reduced; governance is separated from elected officials ▪ Concern that public health becomes a contracted vendor service rather than a core county service ▪ Challenging to launch an authority; might meet resistance from BOCC, who do not want to give up control, and from employees, who fear leaving the state personnel system

BOCC: board of county commissioners; BOH: board of health

Table 3.5. Stakeholders' Perceptions of Consolidated Human Services Agencies

	Benefits	Challenges/Concerns
Finance	▪ May be able to save money and achieve administrative efficiencies by combining human resources, finance, and information technology ▪ Might save on high level salary (if human services director replaces public health, social services, and mental health director positions)	▪ Concern that combining administrative operations would not lead to cost savings or might only be realized in small counties ▪ Concern that public health's prevention role will not compete well for funding with crisis intervention role of other agencies ▪ Might add high level salary (if human services director is added and division directors are retained)
Workforce	▪ Can cross-train staff ▪ Provides an opportunity for shared leadership; division directors can work together to prioritize use of human and financial resources	▪ Requires a leader with training/experience in public health, social services, and mental health, as well as integrated service delivery ▪ Challenge of finding a qualified leader would be magnified for small counties
Service Delivery	▪ Provides an opportunity to coordinate service delivery ▪ Recipients of service (clients) overlap; may be able to minimize or avoid duplication of services	▪ May be challenging to coordinate services, especially because funding streams have numerous restrictions and requirements that define who can receive services ▪ Clients are not the same; overlap is limited and occurs mainly around clinical services, which not all public health agencies provide ▪ Unit of service and missions are different—public health provides prevention services to entire population whereas social services and mental health provide crisis intervention services to subpopulations
Management & Governance	▪ Has lines of authority that are similar to other county departments (health director reports to county manager and all employees fall under county personnel system); enables county manager to more readily promote a "county vision of services" ▪ Can quickly shift resources (human, financial) in an emergency	▪ Concern that health director's effectiveness might be marginalized if core functions (e.g., HR, finance) are centralized ▪ Political insulation with regard to hiring provided by State Personnel Act is lost ▪ Challenging to work across divisions and cultures ▪ Integration of information technology systems across agencies may be costly ▪ Concern about ability of consolidated board (or BOCC) to make effective decisions given need to know rules and regulations of public health, social services, and mental health ▪ Concern that consolidated board is too large

The stakeholder discussions related to public health authorities (see Table 3.4) were more limited in scope than those related to the other types of agencies. This is primarily because many stakeholders lacked familiarity with public health authorities and some were unclear on how the state's two types of authorities (public health and hospital) differed.[57] Some admitted to having no direct knowledge about these types of agencies and offered no views, while others offered views based on their knowledge of public authorities in other sectors (for example, water and sewer).

Conclusion

In the course of focus groups and interviews, stakeholders offered many thoughtful reflections and insights about the four types of local public health agencies in operation in North Carolina. More stakeholders are familiar with county and district health departments and had information to share about those types of agencies. Many expressed a desire to have access to more and better information about all of the different types of agencies, especially with regard to how the agencies compare in terms of performance and efficiency. The next section offers answers to some of these questions, though certainly many more questions remain.

One of the concerns that arose repeatedly during the interviews and focus groups is beyond the scope of this report but is worth highlighting. Numerous stakeholders voiced the opinion that a discussion of the benefits and challenges of different types of local public health agencies should be part of a larger conversation. Given the economic recession, healthcare reform, and other factors affecting public health, these stakeholders expressed a desire for a strategic examination of the overall public health system in the state. As one local public health practitioner explained: "The challenge that I think local public health is going to have is carving out its niche. What is local public health? What does it need to be?"

57. For information about the differences between a public health authority and a public hospital authority, see www.ncphagencies.unc.edu (Additional Legal Q&A).

Part 4. The Numbers: Comparing the Types of Local Public Health Agencies

Questions

- Background
  - What did we want to learn?
  - What types of agencies did we compare?
  - What measures did we analyze and where did we get the data?
- Financing
  - Does source of funding vary by agency type?
  - Do median total expenditures per capita vary by agency type?
  - Do total expenditures per capita vary *within* agency types?
  - Do median expenditures per capita from different funding sources vary by agency type?
  - Do the counties that have transitioned to consolidated human services agencies in the last year have similar financial profiles?
  - Is there evidence that transitioning to a consolidated human services agency will generate savings or increase county expenditures?
- Workforce
  - Do median FTEs per 1,000 population vary by agency type?
  - Do FTEs per 1,000 population vary *within* agency type?
  - Do the counties that have transitioned to consolidated human services agencies in the last year have a similar number of FTEs per 1,000 population as counties in the same population group?
- Information Technology
  - Does the ability to supplement or replace state-provided clinical and billing software vary by agency type?
  - Does the use of mobile technology vary by agency type?
- Services Delivered
  - Does the median percentage of services offered vary by agency type?
  - Do the counties that have transitioned to a consolidated human services agency in the last year provide a similar number of services as counties in the same population group?

Key Findings

- Source of funding appears to be associated with agency type. County health departments and consolidated human services agencies tend to receive a larger percentage of their funding from county appropriations than districts and authorities, which receive a comparatively larger percentage of funding from other sources, such as fees for services.
- Regardless of agency type, as the size of the population served increases, both total expenditures per capita and FTEs per 1,000 population tend to decrease.
- While this research is focused on comparing the different types of agencies, it is important to note that the data indicate that there is as much variation *within* types of agencies as *between* types of agencies for most measures examined.
- Agency type does not appear to be associated with
  - use of mobile technology,
  - ability to supplement or replace state-provided software, or
  - number of public health services provided.

Background

What did we want to learn?

In the report released in May 2012, we wanted to know how the different types of local public health agencies compared with one another in five key areas: financing, workforce, information technology, services delivered, and performance on selected service delivery outputs and community health outcomes. We selected those five areas for comparison after reviewing the academic literature related to public health services and systems as well as the readily available data sources in North Carolina. We conducted both a descriptive statistical analysis and a more complex regression analysis.

For this final report, we updated the comparisons for the two key financial measures: expenditures per capita by funding source and proportion of expenditures by funding source.

We did not update the comparisons in three areas—workforce, information technology, and services delivered—because the data source (North Carolina Local Health Department Survey) had not been updated. Even though we did not update these three comparisons, we included the findings in this final report because they represent the most recent data available and we thought readers might find them useful in the context of the other research presented.

We did not update the more complex regression analysis examining performance on selected service delivery outputs and community health outcomes because we did not find any association between agency type and outputs or outcomes that warranted additional exploration or study. Those findings can be found on pages 51–54 of the May 2012 report, which is available at www.ncphagencies.unc.edu.

What types of agencies did we compare?

We compared all five agency types currently in operation in North Carolina: county health departments, district health departments, consolidated human services agencies, the public health authority, and the hospital authority.[58] Note that all of the data relate to the agencies as they existed *before* legislation was enacted in June 2012.

Given that some of the less-common agency types are associated with population extremes in the state (that is, two consolidated human services agencies serve large populations, and the public health authority serves a small population), and because single-county health departments serve a wide range of population sizes, it was necessary to take population into account when generating these comparisons. Specifically, county health departments were divided into three groups based on population served, as shown in Table 4.1.

Table 4.1. Types of Agencies

	Type of Agency	Number	Population Served
CHD–High Pop	County health department/ High population	24	100,000–500,000
CHD–Med Pop	County health department/ Medium population	23	50,000–99,999
CHD–Low Pop	County health department/ Low population	28	Under 50,000
DHD	District health department	6	41,485–134,307
PHA	Public health authority	1	24,466
HA	Hospital authority	1	181,253
CHSA	Consolidated human services agency	2	925,938–940,697

What measures did we analyze and where did we get the data?

We compared agency types across a variety of measures and gathered data from various publicly available sources (see Appendix C for the data definitions and sources). Some of the data is self-reported by local agencies and has not been independently verified. This includes local expenditure data as reported in the North Carolina Local Health

58. In Cabarrus County, the local public health agency is a public hospital authority. At this time, no other local public health agencies are allowed to convert to a public hospital authority, but they are allowed to convert to a public health authority. The two types of authorities are similar enough that we concluded it would be appropriate to include data from Cabarrus County in this analysis. For more information about public health authorities and public hospital authorities, see www.ncphagencies.unc.edu (Additional Legal Q&A).

Department Revenue Source Books and full-time equivalent (FTE), information technology, and service delivery data as reported in North Carolina Local Health Department Surveys. In the course of updating the financial measures for this final report, we learned that the state did not produce the North Carolina Local Health Department Revenue Source Book in fiscal year 2011. As a result, there is a one-year gap in the data presented in this report.

Financing

Note: Throughout this section, dollars are not adjusted for inflation. Additionally, median figures (rather than averages) are used to minimize the impact of outliers.

Does source of funding vary by agency type?

Yes. Source of funding appears to be associated with agency type.

Four main funding sources are tracked by the state:[59]

- County appropriations
- Medicaid reimbursements
- State and federal funds
- Other revenues

Descriptions of the various funding sources are found in Table 4.2.

As shown in Figure 4.1, county health departments and consolidated human services agencies receive a greater percentage of their funding from county appropriations and a lower percentage of funding from other revenues as compared to district health departments and health authorities.

Between fiscal year 2010 and fiscal year 2012, the proportion of expenditures from any of the four funding sources did not increase or decrease consistently across all agency types. The proportion of expenditures from county appropriations decreased for district health departments and county health departments with high populations. The proportion of expenditures from county appropriations increased for the other five agency types.

59. North Carolina tracks the amount of money spent by local agencies on public health activities from each of these four sources. These figures do not necessarily represent the total revenue generated for each funding source.

Table 4.2. Funding Sources

Funding Source	Description
County appropriations	Portion of local taxes dedicated to public health services.
Medicaid reimbursements	Fees for services and a cost settlement distributed by the state.
State and federal funds	Expenditures of funds from four sources: ▪ General aid to counties (funding awarded on an annual basis by the state to be used at the discretion of the health director); ▪ Funding from the state to support environmental health; ▪ State grants (restricted funding dedicated to specific programs); and ▪ Federal grants (restricted funding dedicated to specific programs). State and federal grants may be competitive, or they may be automatically awarded on the basis of a community's health status. Available data sources do not distinguish between these types of grants.
Other revenues	Any revenues that do not fit into the other three categories, including: ▪ Fees from women's health services and breast cancer and cervical cancer prevention that have mandatory sliding fee scales; ▪ Medicare reimbursements from home health and diabetes care; ▪ Fees from environmental health services; ▪ Grants from private organizations; and ▪ Other similar revenues.

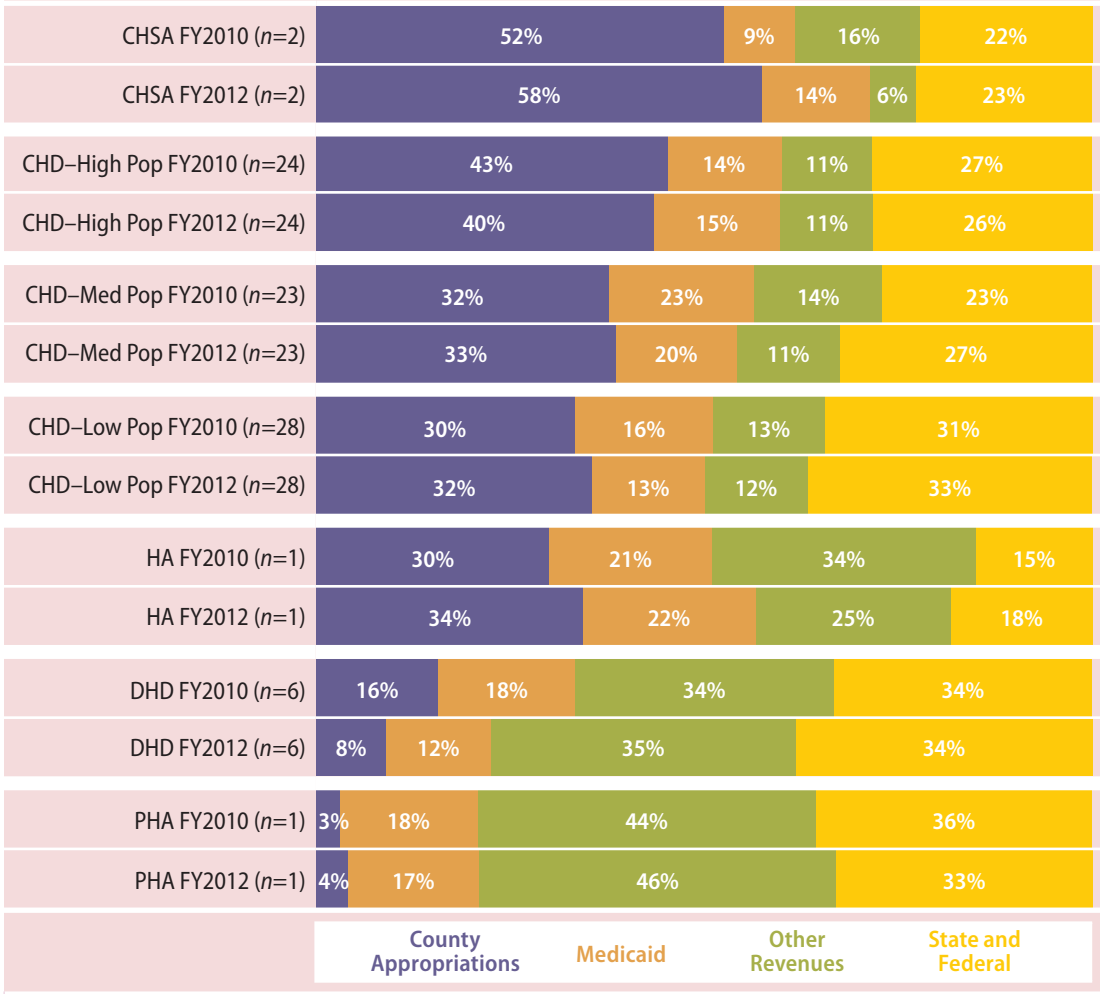
Do median total expenditures per capita vary by agency type?

Yes, but the variation is probably associated more with population size than with agency type. As shown in Figure 4.2 and Table 4.3, there is variation among the agency types with regard to median total expenditures per capita. However, as Figure 4.3 demonstrates, this variation appears to be associated with the size of the population served by the agency independent of agency type (with the exception of hospital authority). In other words, as population size increases, total expenditures per capita tend to decrease. It is also important to note that the relatively high expenditures for the public health authority (Hertford County) may be misleading because a significant portion of the authority's budget is dedicated to funding for a single program that the authority administers in nineteen counties.[60]

Between fiscal year 2010 and fiscal year 2012, every agency type's median total expenditures per capita decreased 9 to 20 percent due to reductions in total expenditures and increases in population, with the exception of district health departments. As a group, district health departments experienced a 2 percent increase. However, there are only six district health departments, and each experienced different fluctuations in expenditures.

60. Email communication from Mr. James Madson, Director, Hertford County Public Health Authority (June 6, 2012) (on file with authors).

Figure 4.1. Median Proportion of Expenditures by Funding Source,* FY2010 and FY2012



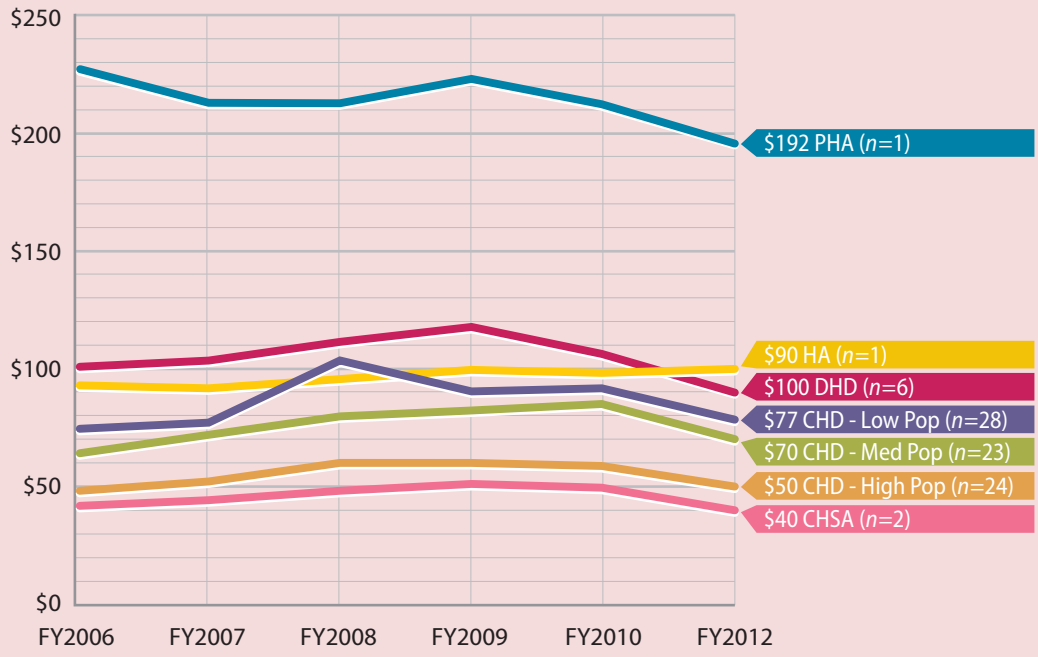
*Percentages do not total 100 percent because median, not mean, figures were used.

Source: NC DHHS Public Health Revenue Source Book, FY2010 and FY2012.

Abbreviations: CHD: county health department; CHSA: consolidated human services agency; DHD: district health department; PHA: hospital authority; PHA: public health authority.

Additionally, the total expenditures for the two consolidated human services agencies reflect very different financial situations. Mecklenburg County experienced a significant reduction in its total expenditures, totaling nearly $10 million, while its population continued to increase. Mecklenburg County's total expenditures per capita were $48 in fiscal year 2010 and $36 in fiscal year 2012. In comparison, Wake County's total expenditures per capita were $51 in fiscal year 2010 and $45 in fiscal year 2012. In 2012, Mecklenburg County increased its county contribution, bringing the proportion of county appropriations to 70 percent. However, it experienced significant decreases in Medicaid reimbursements and other revenues.

Figure 4.2. Median Total Expenditures per Capita, FY2006–FY2012



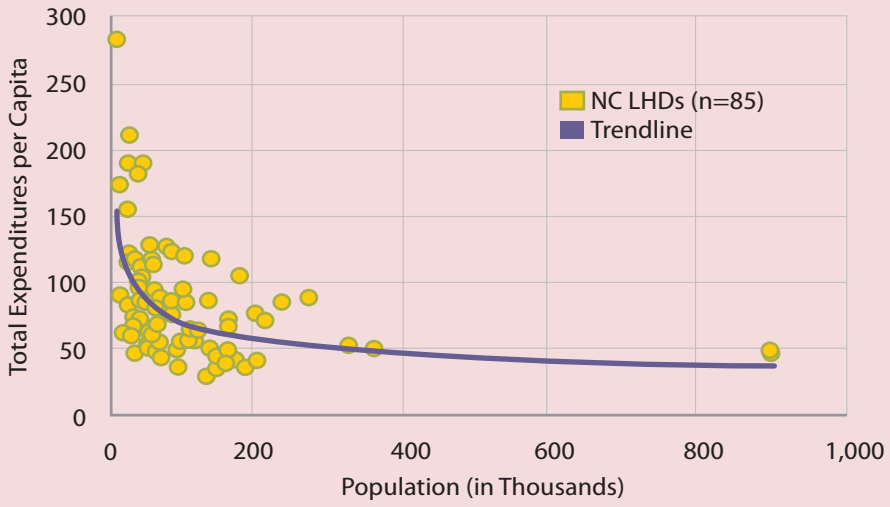
Source: NC DHHS Public Health Revenue Source Book, FY2006–FY2012

Table 4.3. Median Total Expenditures per Capita, FY2006–FY2012

	FY2006	FY2007	FY2008	FY2009	FY2010	FY2012
CHD–High Pop (*n*=24)	48	52	59	60	59	50
CHD–Med Pop (*n*=23)	64	72	80	82	85	70
CHD–Low Pop (*n*=28)	74	77	103	90	91	77
DHD (*n*=6)	92	91	95	99	98	100
CHSA (*n*=2)	42	44	49	51	50	40
PHA (*n*=1)	226	211	212	222	210	192
HA (*n*=1)	100	103	111	117	105	90

Data Source: NC DHHS Revenue Source Book, FY2006, FY2007, FY2009, and FY2010

Figure 4.3. Relationship of Population to Total Expenditures per Capita, FY2010



Data Source: NC DHHS Revenue Source Book, FY2010

Overall, the reductions in expenditures are consistent with data from the National Association of County and City Health Officials, which show that 75 percent of surveyed North Carolina local health departments reported program cuts in calendar year 2011.[61]

Do total expenditures per capita vary *within* agency types?

Yes. There is significant variation in total expenditures per capita *within* agency types, as shown in Table 4.4. In fiscal year 2012, for example, county health departments with low populations had one of the widest ranges, with a minimum total expenditure per capita of $23 and a maximum of $221. In fiscal year 2012, district health departments ranged from a minimum total expenditure per capital of $32 to a maximum of $163.

61. National Association of County and City Health Officials, Research Brief: Local Health Department Job Losses and Program Cuts: State-Level Tables from January/February 2012 Survey (April 2012), available at www.naccho.org/topics/infrastructure/lhdbudget/index.cfm.

Table 4.4. Median (Min-Max) Expenditures per Capita in Dollars by Funding Source, FY2010 and FY2012

Agency Type, Number, and Fiscal Year	Median Size of Population	Total Expenditures per Capita	Expenditures per Capita from County Appropriations	Expenditures per Capita from Medicaid	Expenditures per Capita from Other Revenue	Expenditures per Capita from State and Federal Funds
CHSA (*n*=2) FY10	910,311	50 (48–51)	26 (23–29)	5 (3–7)	8 (5–11)	11 (10–12)
CHSA (*n*=2) FY12	933,318	40 (36–45)	23 (20–25)	6 (0.50–12)	2 (1–3)	9 (9–10)
HA (*n*=1) FY2010	178,011	105	32	22	35	16
HA (*n*=1) FY2012	181,253	90	31	20	23	17
CHD-High Pop (*n*=24) FY2010	162,878	59 (37–90)	23 (12–63)	8 (3–22)	6 (0–27)	15 (8–32)
CHD-High Pop (*n*=24) FY2012	162,443	50 (34–84)	20 (8–58)	7 (1–22)	6 (2–32)	13 (6–33)
CHD-Med Pop (*n*=23) FY2010	63,505	85 (39–129)	27 (8–48)	16 (3–57)	12 (1–48)	18 (10–39)
CHD-Med Pop (*n*=23) FY2012	64,553	70 (32–133)	22 (5–55)	14 (4–58)	7 (0–72)	17 (9–35)
CHD-Low Pop (*n*=28) FY2010	30,444	91 (48–282)	30 (6–89)	13 (0–83)	12 (1–73)	28 (16–89)
CHD-Low Pop (*n*=28) FY2012	30,570	77 (23–221)	28 (5–102)	11 (0–57)	10 (0–70)	26 (15–59)
DHD (*n*=6) FY2010	97,427	98 (31–189)	9 (7–22)	13 (0–51)	34 (0–68)	33 (21–60)
DHD (*n*=6) FY2012	98,512	100 (32–163)	6 (1–20)	16 (0–57)	38 (5–68)	34 (20–50)
PHA (*n*=1) FY2010	24,669	210	6	37	93	75
PHA (*n*=1) FY2012	24,466	192	8	32	88	64

Source: NC DHHS Public Health Revenue Source Book, FY2010 and FY2012
Abbreviations: CHD: county health department; CHSA: consolidated human services agency; DHD: district health department

Do median expenditures per capita from different funding sources vary by agency type?

The answer to this question varies by the type of funding source.

- **County appropriations.** Expenditures from county appropriations appear to be associated with agency type. Consolidated human services agencies and county health departments have higher median expenditures per capita from county appropriations than district health departments and the public health authority. See Table 4.5.
- **Medicaid reimbursements.** Expenditures from Medicaid reimbursements do not appear to be associated with agency type, but they do appear to be associated with population. As population increases, expenditures per capita from Medicaid reimbursements tend to decrease. See Table 4.6.
- **State and federal sources.** Expenditures from state and federal sources do not appear to be associated with agency type. See Table 4.7.

Table 4.5. Median, Minimum, and Maximum County Appropriations, per Capita, in FY2012

	Median	Minimum	Maximum
CHD–High Pop (*n*=24)	20	8	58
CHD–Med Pop (*n*=23)	22	5	55
CHD–Low Pop (*n*=28)	28	5	102
DHD (*n*=6)	6	1	20
CHSA (*n*=2)	26	23	29
PHA (*n*=1)	8		
HA (*n*=1)	31		

Source: NC DHHS Public Health Revenue Source Book, FY2012

Table 4.6. Median, Minimum, and Maximum Medicaid Expenditures, per Capita, in FY2012

	Median	Minimum	Maximum
CHD–High Pop (*n*=24)	7	1	22
CHD–Med Pop (*n*=23)	14	4	58
CHD–Low Pop (*n*=28)	11	0	57
DHD (*n*=6)	16	0	57
CHSA (*n*=2)	6	0.50	12
PHA (*n*=1)	32		
HA (*n*=1)	20		

Source: NC DHHS Public Health Revenue Source Book, FY2012

- **Other revenues.** Expenditures from other revenues appear to be associated with agency type. District health departments, the public health authority, and the hospital authority have higher median expenditures per capita from other revenues than consolidated human services agencies and county health departments. See Table 4.8.

Note that there is significant variation *within* agency types for all funding sources.

Table 4.7. Median, Minimum, and Maximum State and Federal Expenditures, per Capita, for FY2012

	Median	Minimum	Maximum
CHD–High Pop (*n*=24)	13	6	33
CHD–Med Pop (*n*=23)	17	9	35
CHD–Low Pop (*n*=28)	26	15	59
DHD (*n*=6)	34	20	50
CHSA (*n*=2)	9	9	10
PHA (*n*=1)	64		
HA (*n*=1)	17		

Source: NC DHHS Public Health Revenue Source Book, FY2012

Table 4.8. Median, Minimum, and Maximum Other Revenue Expenditures, per Capita, in FY2012

	Median	Minimum	Maximum
CHD–High Pop (*n*=24)	6	0	27
CHD–Med Pop (*n*=23)	7	0	72
CHD–Low Pop (*n*=28)	10	0	70
DHD (*n*=6)	38	5	68
CHSA (*n*=2)	2	1	3
PHA (*n*=1)	88		
HA (*n*=1)	23		

Source: NC DHHS Public Health Revenue Source Book, FY2012

Do the counties that have transitioned to consolidated human services agencies in the last year have similar financial profiles?

No. There is wide variation among the seven counties that have transitioned to CHSAs since the new legislation was enacted. See Tables 4.9 and 4.10 and Figure 4.4. Three of the new CHSAs are in high-population counties, one is in a medium-population county, and three are in low-population counties. Expenditures from county appropriations were relatively stable in five of the seven counties between fiscal year 2010 and fiscal year 2012, while the other two counties experienced significant changes. In Edgecombe County, expenditures from county appropriations *increased* from $31 to $55 per capita and expenditures from Medicaid and other revenues decreased. In Union County, expenditures from county appropriations *decreased* from $20 to $8 per capita and expenditures from Medicaid increased from $12 to $16 per capita.

Table 4.9. Expenditures per Capita in Dollars by Funding Source: Recently Transitioned Counties (CHS Board as Governing Board), FY2010 and FY2012

LHD and Fiscal Year	Population	State and Federal Per Capita	County Appropriations Per Capita	Medicaid Per Capita	Other Revenue Per Capita	Total Per Capita
Union FY2010	196,322	9	20	12	2	43
Union FY2012	205,717	8	8	16	3	35
Buncombe FY2010	230,421	23	31	17	15	86
Buncombe FY2012	243,855	18	31	10	7	66
Edgecombe FY2010	51,327	39	31	23	37	129
Edgecombe FY2012	56,089	35	55	6	12	108

Source: NC DHHS Public Health Revenue Source Book, FY2012

Table 4.10. Expenditures per Capita in Dollars by Funding Source: Recently Transitioned Counties (BOCC as Governing Board), FY2010 and FY2012

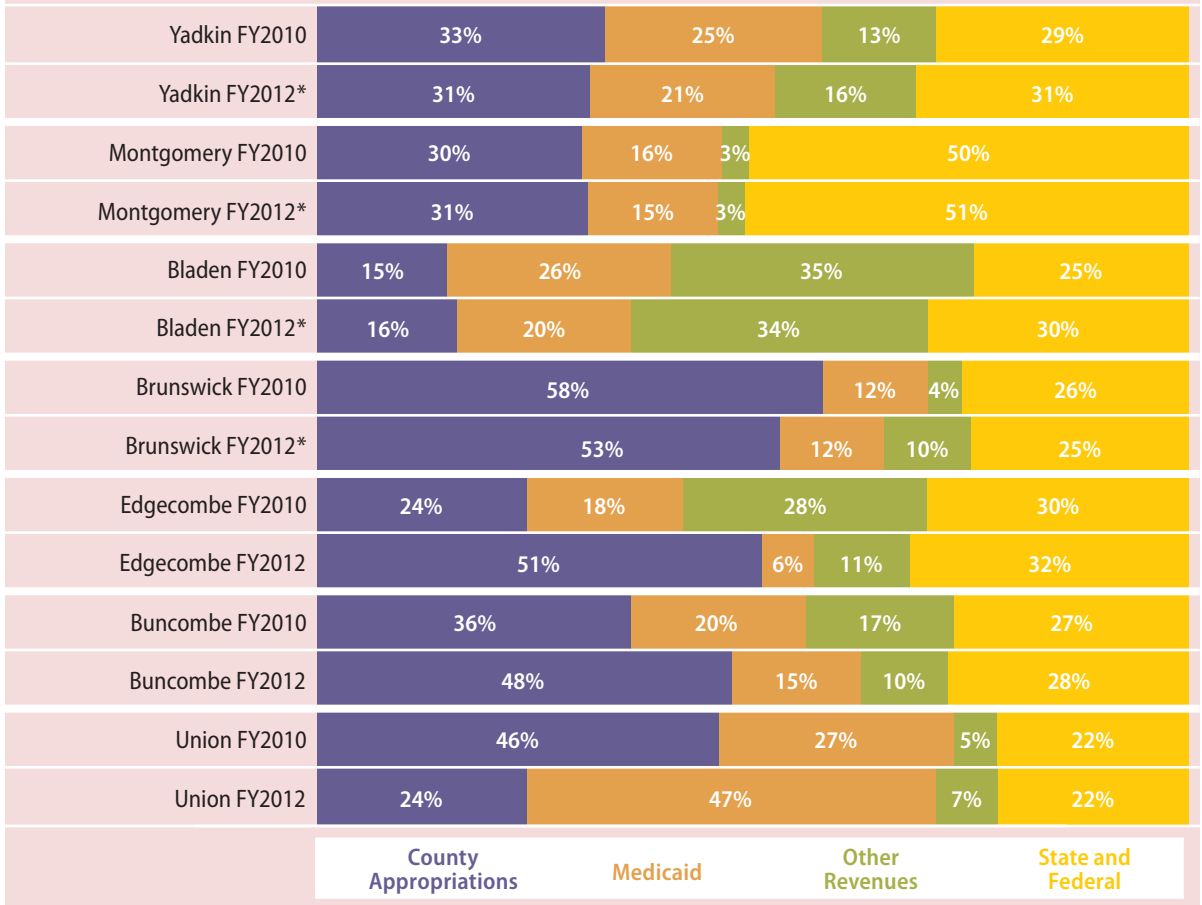
LHD and Fiscal Year	Population	State and Federal Per Capita	County Appropriations Per Capita	Medicaid Per Capita	Other Revenue Per Capita	Total Per Capita
Brunswick FY2010	107,127	16	34	7	2	60
Brunswick FY2012	110,140	12	26	6	5	49
Bladen FY2010	32,043	29	17	30	42	119
Bladen FY2012	35,148	33	18	23	38	112
Montgomery FY2010	27,983	34	20	11	2	68
Montgomery FY2012	27,864	35	21	10	2	67
Yadkin FY2010	37,996	22	25	19	10	75
Yadkin FY2012	38,442	18	18	12	9	58

Source: NC DHHS Public Health Revenue Source Book, FY2012

Is there evidence that transitioning to a consolidated human services agency will generate savings or increase county expenditures?

At this point, the data do not show that transitioning to a CHSA will generate savings or increase county expenditures. While Wake and Mecklenburg counties have operated CHSAs for extended periods of time, these two counties have unique characteristics—namely, they are very urban and populous—that make it difficult to generalize their experiences to other counties. The counties that have recently transitioned to CHSAs have not operated long enough to have data that show any potential changes in financing.

Figure 4.4. Median Proportion of Expenditures by Funding Source, FY2010 and FY2012



*LHDs that have adopted Mecklenburg model: CHSA with BOCC as Board. All other LHDs listed have adopted Wake model: CHSA with CHSA Board.

Source: NC DHHS Public Health Revenue Source Book, FY2010 and FY2012.

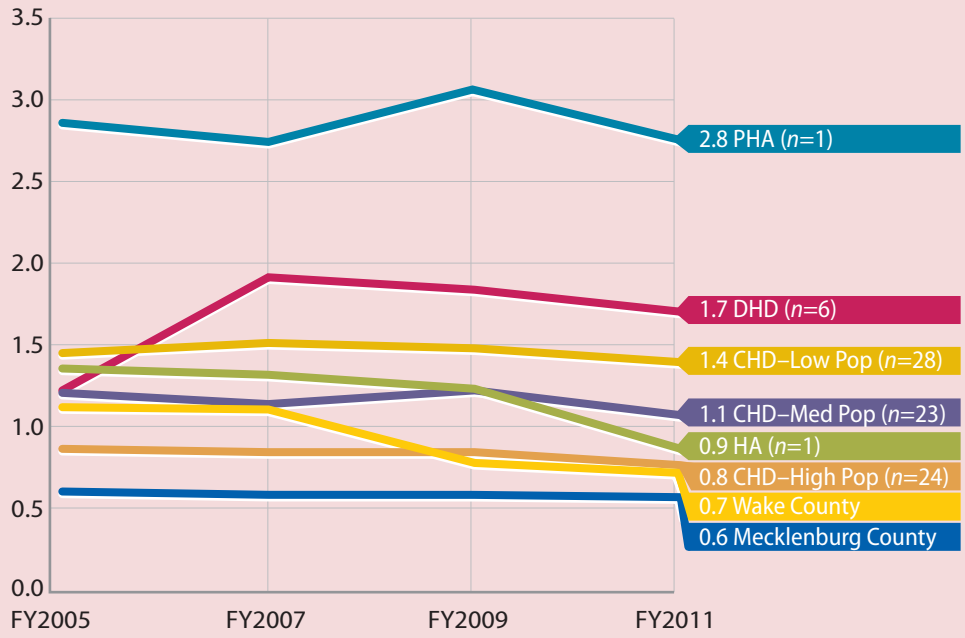
Workforce

Do median FTEs per 1,000 population vary by agency type?

Yes, but the variation is probably associated more with population size than with agency type. As shown in Figure 4.5 and Table 4.11, there is variation among the agency types with regard to FTEs[62] per 1,000 population. However, as Figure 4.6 demonstrates, this variation appears to be associated with the size of the population served by the agency independent of agency type. In other words, agencies with larger populations tend to have fewer FTEs per 1,000 population.

62. FTE counts include funded full-time positions (filled and vacant) as well as part-time and contract positions. The total number of weekly part-time hours was converted to FTEs by dividing by 40, whereas the total number of annual contract hours was divided by 2000. A rate of FTEs per 1,000 was calculated for each LHD using survey data as the numerator and population estimates from North Carolina State Center for Health Statistics as the denominator.

Figure 4.5. Median FTEs per 1,000 Population, FY2005–FY2011



Data Source: NC LHD Survey, FY2005, FY2007, FY2009, FY2011

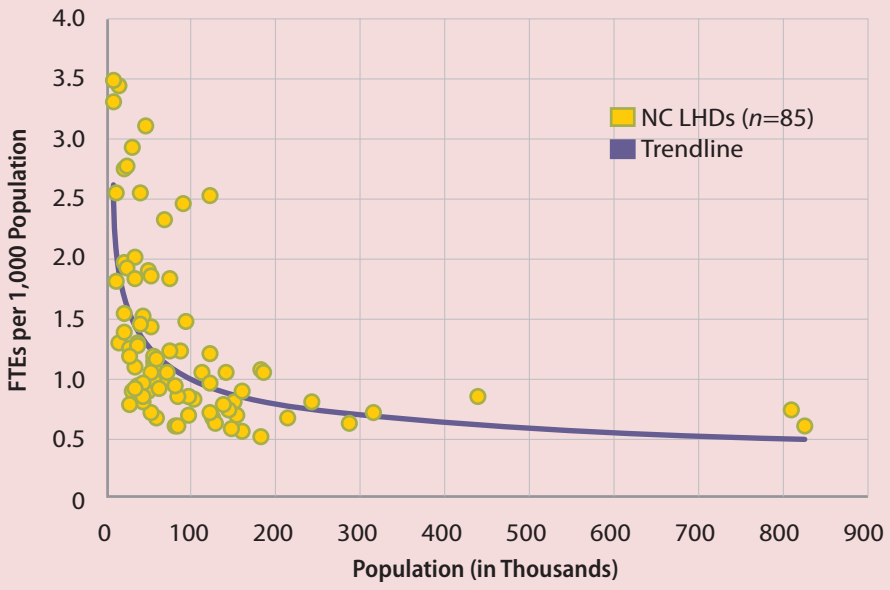
Table 4.11. Median Number of FTEs per 1,000 Population, FY2005–FY2011

	FY2005	FY2007	FY2009	FY2011
CHD–High Pop (*n*=24)	0.9	0.9	0.9	0.8
CHD–Med Pop (*n*=23)	1.2	1.1	1.2	1.1
CHD–Low Pop (*n*=28)	1.5	1.5	1.5	1.4
DHD (*n*=6)	1.2	1.9	1.9	1.7
PHA (*n*=1)	2.9	2.8	3.1	2.8
HA (*n*=1)	1.4	1.3	1.2	0.9
CHSA (*n*=2)	0.9	0.9	0.7	0.7
Mecklenburg County	0.6	0.6	0.6	0.6
Wake County	1.1	1.1	0.8	0.7

Data Source: NC LHD Survey, FY2005, FY2007, FY2009, FY2011

Note that in Figure 4.5, the two consolidated human services agencies (Wake and Mecklenburg counties), are shown separately because they have different approaches to service delivery which may affect FTEs per 1,000 population. During this time period (fiscal year 2005 to fiscal year 2011), Mecklenburg County contracted with a private provider to deliver most public health services, creating a lower FTE count than Wake County, which provided most public health services directly.

Figure 4.6. Relationship of Population to FTEs per 1,000 Population, FY2011



Data Source: NC LHD Survey, FY2011

Do FTEs per 1,000 population vary *within* agency type?

Yes. There appears to be more variation *within* agency type than *between* agency types. See Table 4.12. For example, county health departments with a medium population range from a minimum of 0.6 FTEs per 1,000 population to a maximum of 2.5.

Table 4.12. Median, Minimum, and Maximum FTEs per 1,000 Population, FY2011

	Median	Minimum	Maximum
CHD–High Pop (*n*=24)	0.8	0.5	1.5
CHD–Med Pop (*n*=23)	1.1	0.6	2.5
CHD–Low Pop (*n*=28)	1.4	0.8	3.5
DHD (*n*=6)	1.7	0.7	3.1
CHSA (*n*=2)	2.8	2.8	2.8
PHA (*n*=1)	0.9	0.9	0.9
HA (*n*=1)	0.7	0.6	0.7

Data Source: NC LHD Survey, FY2011

Do the counties that have transitioned to consolidated human services agencies in the last year have a similar number of FTEs per 1,000 population as counties in the same population group?

Yes. In the seven counties that have transitioned to consolidated human services agencies in the last year, the number of FTEs per 1,000 population is comparable to the median number of FTEs per 1,000 population for their respective population groups. See Table 4.13.

Table 4.13. Comparing FTEs per 1,000 Population: Recently Transitioned Counties versus Median for Population Group, FY 2011

County	Percentage for Selected County	Median for County Population Group
Bladen (Low Pop)	1.8	1.4
Brunswick (High Pop)	0.8	0.8
Buncombe (High Pop)	0.7	0.8
Edgecombe (Med Pop)	1.8	1.1
Montgomery (Low Pop)	1.2	1.4
Union (High Pop)	0.5	0.8
Yadkin (Low Pop)	0.9	1.4

Data Source: NC LHD Survey, FY2011

Information Technology

Does the ability to supplement or replace state-provided clinical and billing software vary by agency type?

No. The ability to supplement or replace state-provided clinical and billing software does not appear to vary by agency type.

The state provides all local public health agencies with a billing and clinical management software program called Health Information System (HIS). All agencies have the option of contracting with outside vendors to supplement or replace the state-provided software program. Based on self-reported survey data summarized in Table 4.14,[63] it appears that all types of agencies are purchasing alternate or supplemental software. Local public health agencies with larger populations appear to be exercising this option at a higher rate.

63. Results of the FY2011 North Carolina Local Health Department Survey, administered by the N.C. Department of Public Health on a biennial basis, provide the data for this measure. Given the rapid pace of change in technology, we use only the results of the FY2011 survey. The FY2011 survey achieved a 100 percent response rate. All data were self-reported and not independently verified, representing a potential limitation to this measure.

Table 4.14. Percentage of Agencies That Supplemented or Replaced the State-Provided HIS Software, FY2011

	Clinical Software	Billing Software
CHD–High Pop (*n*=24)	42 (10/24)	79 (19/24)
CHD–Med Pop (*n*=23)	35 (8/23)	61 (14/23)
CHD–Low Pop (*n*=28)	32 (9/28)	50 (14/28)
DHD (*n*=6)	83 (5/6)	67 (4/6)
PHA (*n*=1)	100 (1/1)	100 (1/1)
HA (*n*=1)	100 (1/1)	100 (1/1)
CHSA (*n*=2)	50 (1/2)	100 (2/2)

Data Source: NC LHD Survey, FY2011

Does the use of mobile technology vary by agency type?

No. The use of mobile technology does not appear to vary by agency type. See Table 4.15.

Mobile technologies enable staff to work and access information remotely. Tools such as smartphones and tablets represent some of the most recent developments in mobile technology. Of the agencies using smartphones and tablets, the median number of mobile devices per FTE is 0.08.

Table 4.15. Percentage of Agencies Using Mobile Technology, FY2011

	Wireless Internet	Virtual Private Network	Geographic Info System	Global Positioning System	Smartphones or Tablets
CHD–High Pop (*n*=24)	75 (18/24)	92 (22/24)	96 (23/24)	33 (8/24)	83 (20/24)
CHD–Med Pop (*n*=23)	78 (18/23)	74 (17/23)	96 (22/23)	17 (4/23)	61 (14/23)
CHD–Low Pop (*n*=28)	68 (19/28)	54 (15/28)	79 (22/28)	32 (9/28)	71 (20/28)
DHD (*n*=6)	33 (2/6)	67 (4/6)	17 (1/6)	0 (0/6)	50 (3/6)
PHA (*n*=1)	100 (1/1)	100 (1/1)	0 (0/1)	0 (0/1)	0 (0/1)
HA (*n*=1)	100 (1/1)	100 (1/1)	100 (1/1)	100 (1/1)	100 (1/1)
CHSA (*n*=2)	100 (2/2)	100 (2/2)	100 (2/2)	50 (1/2)	50 (1/2)

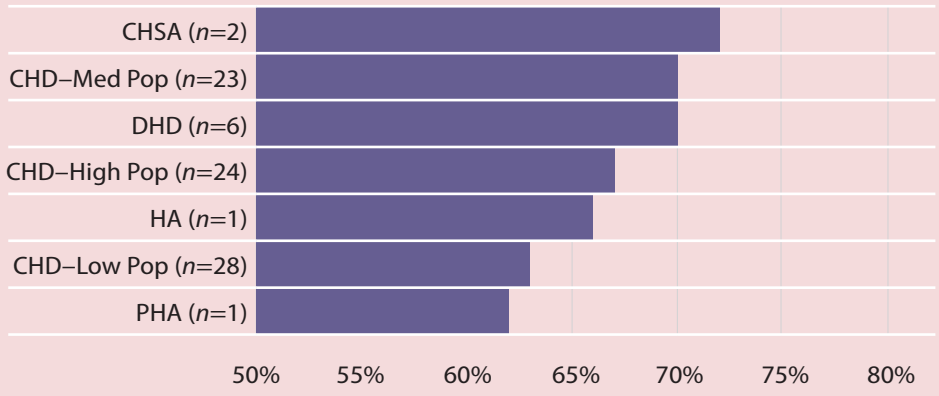
Data Source: NC LHD Survey, FY2011

Services Delivered

Does the median percentage of services offered vary by agency type?

We explored the relationship between agency type and number of services offered by examining the percentage of 127 public health services and activities that each agency offered in fiscal year 2011.[64] As shown in Figure 4.7, there was only a ten percentage point difference in the median share of tracked service activities offered across agency types, suggesting that agency type does not have a major impact on number of services offered. While there is little variation *between* agency types, there is substantial variation *within* agency types (see Table 4.16).

Figure 4.7. Median Percentage of 127 Public Health Activities Offered by Agency Type, FY2011



Data Source: NC LHD Survey, FY2011

Table 4.16. Median Percentage of 127 Services Offered by Agency Type, FY2011

	Median	Minimum	Maximum
CHD–High Pop (*n*=24)	67	56	87
CHD–Med Pop (*n*=23)	70	49	85
CHD–Low Pop (*n*=28)	63	48	91
DHD (*n*=6)	70	51	80
PHA (*n*=1)	62	62	62
HA (*n*=1)	66	66	66
CHSA (*n*=2)	72	69	75

Data Source: NC LHD Survey, FY2011

64. See Appendix A for a list of the full range of 127 services included in the survey.

Do the counties that have transitioned to a consolidated human services agency in the last year provide a similar number of services as counties in the same population group?

Yes. In general, the number of tracked services provided by counties that transitioned in the last year to a consolidated human services agency is comparable to the median number of services provided by all counties in the same population group. Brunswick County is an exception in that it provides fifty-six tracked services when the median for the population group is sixty-seven. See Table 4.17.

Table 4.17. Comparing Percentage of 127 Public Health Activities: Recently Transitioned Counties versus Median for Population Group, FY 2011

County	Percentage for Selected County	Median for County Population Group
Bladen (Low Pop)	62	63
Brunswick (High Pop)	56	67
Buncombe (High Pop)	65	67
Edgecombe (Med Pop)	72	70
Montgomery (Low Pop)	65	63
Union (High Pop)	62	67
Yadkin (Low Pop)	64	63

Data Source: NC LHD Survey, FY2011

Conclusion

When this research project began, North Carolina already had many different types of local public health agencies in operation across the state. When legislation related to the organization and governance of these agencies was enacted in June 2012, the local public health landscape began to shift almost immediately. Several counties abolished local boards of health or established consolidated human services boards. Several counties consolidated public health with other county departments, primarily departments of social services. Several more counties are planning to implement a change soon or are considering their options for change.

This research provides an important baseline for state and local policymakers as they evaluate the impact of all of these changes in the years to come. Future researchers may want to build on our research to answer questions, such as

- Have the financial profiles of the newly consolidated human services agencies changed?
- Are counties contributing more or less money to support the agencies?
- How have the workforces of the newly consolidated agencies changed?
- Are the newly consolidated agencies offering more or fewer public health services?
- How have governance changes affected the work of the agencies?
- Have perceptions about the types of agencies shifted as more counties transition to consolidated human services agencies?
- Have new district (regional) health departments been established? If so, how did the change affect the participating counties?

Although the project funded by the Robert Wood Johnson Foundation is complete, we expect to continue to track legislative developments and policy choices at the local level. If we are able to secure additional support in the coming years, we may also try to update some of the data and answer some of these questions or others that emerge. As with all of our research in this evolving area, we will post any updates online at www.ncphagencies.unc.edu.

Appendixes

All appendixes are available online at www.ncphagencies.unc.edu. The website also includes supplementary material, such as more detailed questions and answers about the different types of local public health agencies.

Appendix A: North Carolina Local Health Department Survey Public Health Service Categories and Activities (FY2011)

Appendix B: Perspectives of Stakeholders: Comprehensive Findings

Appendix C: Data Definitions and Sources

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