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CHAPTER 9

STRENGTHENING STRUCTURE AND INNOVATION IN LOCAL PUBLIC HEALTH

Local public health departments face constant change because they are rooted deeply in the communities they serve. They must adjust to demographic shifts in the local population, gains and losses in the local economy, changes in political power, and emerging research in public health that illuminates new paths forward. These realities demand that successful local health departments become adept at implementing innovative strategies to improve the health of our communities in collaboration with many other important partners.

Across North Carolina, local health departments are forging new partnerships, learning new skills, and modernizing public health services. For example, during the COVID-19 pandemic, the Guilford County Health Department partnered with local "influencers" on social media to promote understanding and uptake of vaccines and boosters. The influencers were able to reach new groups of people, hear their questions and concerns, and provide science-based information to facilitate informed decision-making about vaccines.[1] In Cabarrus County, a coalition including Cabarrus Health Alliance, EMS, law enforcement, county government, and local service providers and nonprofits work together to provide a coordinated system of overdose response, prevention, harm reduction, and treatment services to people who are using opioids.[2]

There is a vast body of organizational research on the necessary and enabling elements of innovation in organizations. Much of this research has a "Goldilocks" quality—you need adequate resources for efficiency and experimentation, with clear lines of accountability; you need rules but not rigidity; you need sufficient time for reflection but deadlines to provide focus.[3] In this chapter, we focus on foundational elements of public health—accreditation standards, governance models, regional resource sharing, and funding mechanisms—as necessary structures to drive innovation and improve the health and well-being of entire populations. When these foundations are strong, health departments have the necessary structure, flexibility, resources, and resilience to develop new approaches to accomplish their goals.

Accreditation as a Foundation for Innovation

Local health department accreditation represents one important aspect of the strong foundation needed by public health organizations. North Carolina was an early adopter of accreditation for local health departments and in 2005 became the first state in the nation to require accreditation at the local level.[4] Accreditation establishes uniform standards across all health departments and provides assurance to the public that a local agency meets baseline standards and competencies in service provision, oversight, and administrative processes. It also strengthens accountability and credibility and aims to promote quality improvement within local health departments.[5] Accreditation benchmarks and activities help to define the industry standard and foster innovation by providing a common baseline understanding of the rules, emphases, and core issues that lie at the heart of solid local public health practice, spurring creative solutions to new and persistent health challenges.

Effective Governance Can Guide Innovation

The leadership team at each local health department is responsible for achieving accreditation, and is accountable to a local governing board that sets local rules and agency policy, appoints the local health director (often in consultation with the County Board of Commissioners), and that serves as the adjudicatory body for public health in that community.[6] This governing board can take one of several forms, such as a county or district Board of Health, or a local Consolidated Human Services board in counties with a merged public health and social services agency. Legislation enacted in 2012 also gave all counties in North Carolina the option to abolish the Board of Health; in these counties, the Board of Commissioners serves in this role and appoints an advisory committee.[6] Given this level of oversight, local public health is highly accountable to elected and appointed leaders that live in that community and therefore are close to the issues the local health department is tackling.

At their best, and no matter their form, the governing authority of a local health department provides the leadership team and staff with support, guidance, and accountability. These authorities speak with one voice to their communities, especially in controversial situations, providing elected officials and the public with science-based explanations for public health rules and actions. They may also consult with elected officials in cities and counties to provide guidance on policies and planning approaches that will promote and protect health. Effective governance in local health departments is a key element of innovation, providing strategic direction and support to the agency as a whole and advocating for resources to address priority issues.

Regional Collaboration as Innovation

Boards of Health may set fees for health department services, but they do not make local funding decisions. It is the responsibility of county commissioners to decide on the levels of funding provided by local revenue to public health departments. Some counties have decided that their public health resources are most efficiently stewarded through multi-county districts or through regional collaboration. All local health departments collaborate with counterparts in other counties to some degree; there is a wide range of levels of collaboration, from informal information sharing all the way up to the formal creation of multi-county health departments or authorities. The decision to collaborate has many underlying reasons, relating often to performance and effectiveness goals as well as financial stewardship.

Public health leaders, especially in smaller health departments, are famous for "wearing many hats." It is common to find that one person will be tasked with multiple, disparate responsibilities; for example, someone may serve simultaneously as a nursing supervisor, communicable disease coordinator, emergency preparedness planner, and public information officer. Other health departments could have a full-time person in each of these roles. Counties may pool resources for shared personnel if their funding does not stretch to fill all these roles. They may also find that it is advantageous to work together to develop new programs, such as collaborative efforts between counties to address health issues that affect many communities (e.g., chronic disease and opioid misuse). Figure 13 illustrates the range of collaborative options available.

Figure 13. Spectrum of Sharing Arrangements

Source: The Center for Sharing Public Health Services at the Public Health Accreditation Board. https://phaboard.org/initiatives/centerforsharing/

The Health Department and Clinical Health Services

Sufficient and appropriate financial resources are also critically important for local health departments to effectively provide core services and to fund innovative improvement efforts. Please see Chapter 10 for a detailed discussion of local public health funding; we address a more specific issue of public health funding here. In Chapter 1 of this report, we distinguished public health from health care by emphasizing that public health focuses on population-level initiatives such as policy and system change, infrastructure improvements, and community education, while health care focuses on clinical services and individual health. However, in practice there are many public health departments that provide both population-level and individual services. This stems in part from public health's obligation under North Carolina General Statute § 130A-1.1 to "link[] people to needed personal health care services and ensur[e] the provision of health care when otherwise unavailable."[7]

In addition, across North Carolina, thousands of individuals utilize the health department to receive health care services, such as prenatal medical care, dental care, treatment for sexually transmitted infections, counseling and medications for substance use disorders, access to family planning services, and many other health care services. Sometimes people turn to the health department for their care because those services simply aren't provided elsewhere in their communities, and sometimes they do so because these services exist but are difficult to access without health insurance and on limited incomes. It is also important to note that health departments are not simply providers of last resort for people without economic advantages; in many communities, the staff and agencies of the local public health department are trusted for the quality and competence of the care they provide. These services can also help to cross-subsidize other health department services.

Because of the need to fill in these health care service gaps, health departments —particularly in rural areas—face dilemmas and obstacles to focusing on the core mission of public health (i.e., to address the health and well-being of whole communities). In places where access to health care is limited, health departments serve as vital health care safety net providers, and the payments they receive for providing health care services are an essential resource for their limited budgets. Many health departments rely on clinical revenues to support their core mission to provide population health services.

With opportunities for innovation to enhance local public health's ability to improve the health of the whole community, the task force recommends the following:

RECOMMENDATION 6

Pursue innovative strategies to address broader population health and meet the organizational, funding, and workforce challenges that local governmental public health currently faces

Three strategies are recommended by the Task Force on the Future of Local Public Health to move to a future vision of a strengthened structures for innovation:

Strategy 6a. Support Accreditation Flexibility and Modernize Standards The North Carolina Local Health Department Accreditation (NCLHDA) Board should support health departments as they pursue best available options to modernize their workforce, data capabilities, partnership development, and activities to address broader population health in communities by (1) exploring options to incorporate reciprocity for accreditation through the Public Health Accreditation Board (PHAB) in lieu of accreditation through NCLHDA and (2) restructuring the rules for accreditation to ensure the process is reflective of evolving standards for the new 10 Essential Public Health Services and/or the Foundational Public Health Capabilities.

Strategy 6b. Evaluate Innovative Models and Best Practices The North Carolina Institute for Public Health should (1) collaborate with the UNC School of Government, and/or identify other organizations as needed, to analyze innovative models and best practices for local governmental public health governance structures and partnership models and provide recommendations to guide future discussions around improving population health of North Carolinians and (2) collaborate with the North Carolina Association of Local Health Directors, and/or other organizations as needed, to evaluate and provide a report on overarching themes and lessons learned from health departments that have partnered with health care entities in their communities to shift health service provision from health department responsibility.

Strategy 6c. Support Opportunities for Innovation The North Carolina General Assembly should support innovation and efforts to address population health in local public health by (1) allocating significant funds to sustain existing and developing regional local public health capabilities in workforce, data, and communications and incentivize additional regional collaboration to realize opportunities for efficiencies across local public health jurisdictions and (2) supporting the development of rural safety net providers by filling the Medicaid coverage gap.

Strategy 6a – Support Accreditation Flexibility and Modernize Standards

Building on North Carolina's critical legislation requiring accreditation for local health departments, the North Carolina Local Health Department Accreditation (NCLHDA) Board should support health departments as they pursue best available options to modernize their workforce, data capabilities, partnership development, and activities to address broader population health in communities by:

i. Explore options to incorporate reciprocity for accreditation through the Public Health Accreditation Board (PHAB) in lieu of accreditation through NCLHDA with the ability to address topics not covered by PHAB accreditation through separate NCLHDA modules, as well as continuing discussions with PHAB regarding reciprocity for NCLHDA Board accreditation.

ii. Restructuring the rules for accreditation to ensure the process is reflective of evolving standards for the new 10 Essential Public Health Services and/or the Foundational Public Health Capabilities.

Desired Result

Local health departments will have fully modernized standards for accreditation and be positioned favorably with future Public Health Accreditation Board requirements.

Why does the task force recommend this strategy?

As an early adopter of mandatory health department accreditation, North Carolina has been a leader in standards-based accountability for local public health across the United States. In recent years, more health departments across the country have begun pursuing accreditation through the national Public Health Accreditation Board (PHAB) and some grant funders at the national level are most familiar with that form of accreditation. The task force wants to explore options for North Carolina health departments that prefer to seek accreditation through PHAB to have that flexibility, yet also wants to ensure all North Carolina-based standards are met. At the same time, North Carolina's standards should reflect any revision of the 10 Essential Public Health Services and the Foundational Public Health Capabilities.

Additional Context

Accreditation of health departments in the state is a multi-phase process overseen by the **North Carolina Local Health Department Accreditation (NCLHDA) Program**, and agencies must seek renewal of their accreditation status every four years to maintain eligibility for state and federal funding.[A] Health departments in North Carolina are required to provide documentation of their performance in three domains, called standards (Agency Core Functions and Essential Services, Agency Facilities and Administrative Services, and Board of Health/Governance), organized into 41 benchmarks and 147 activities to meet those benchmarks.[5] Because North Carolina established its accreditation program so early, the standards and process are specific to North Carolina, though aligned with national frameworks,[B] and the NCLHDA has served as a model for national accreditation programs administered through PHAB.[8]

PHAB reports that its accreditation covers 90% of the United States population, with 40 state, 305 local, and five Tribal health departments receiving PHAB accreditation.[C,9] Although most local health departments across the country are not required to seek this form of accreditation, many do for a variety of reasons, with 47% of health departments that applied for PHAB accreditation reporting that they did so for greater competitiveness for funding opportunities.[10] In North Carolina, health departments are required to be accredited through NCLHDA and may also seek PHAB accreditation separately. Burke County Health Department and Cabarrus Health Alliance/Public Health Authority are the only two local health departments in the state that have received PHAB accreditation, as has Fort Bragg Department of Public Health.[D,9]

North Carolina's accreditation standards are based on the 10 Essential Public Health Services ("10 Essential Services," See Figure 3, Page 21). The 10 Essential Services identify the activities all communities should engage in to carry out the mission of public health, and the original framework maps to the essential services mandated in North Carolina state law.[E] An update to the framework in 2020 placed equity at the center to emphasize the responsibility of local public health to ensure all community members have the opportunity to live healthy lives through implementation of the essential services. North Carolina law and accreditation standards have not yet been updated to reflect this change.

How would this impact the health of communities?

Fully accredited health departments are held accountable for maintaining standards and are incentivized to focus on quality improvement. This helps to ensure that local public health is fulfilling its roles and responsibilities to promote health for the communities served in a consistent manor across all counties irrespective of size, resources, or other demographics.

Who is responsible?

- North Carolina Local Health Department Accreditation Board

Who are the partners?

- North Carolina Institute for Public Health
- Public Health Accreditation Board (national)

[A] *N.C. GEN. STAT. ANN. § 130A-34.4(a)(1)*

[B] *Such as the National Association of City and County Health Official's (NACCHO) "Operational Definition of a Functional Local Health Department." https://www.naccho.org/uploads/downloadable-resources/Operational-Definition-of-a-Functional-Local-Health-Department.pdf*

[C] *While the population served by PHAB-accredited health departments is large, only 305 of the nearly 3,000 local health departments nationwide are PHAB-accredited. This amounts to 10% of local health departments nationwide, whereas 100% of North Carolina local health departments are accredited within the state accreditation system.*

[D] *Fort Bragg is an Army installation in Cumberland and Hoke Counties in North Carolina.*

[E] *NC § 130A-1.1. Mission and essential services; see also G.S. 130A-34.1. Accreditation of local health departments; board established.*

Strategy 6b – Evaluate Innovative Models and Best Practices

The North Carolina Institute for Public Health should:

i. Collaborate with the University of North Carolina School of Government, and/or other organizations as needed, to analyze innovative models and best practices for local governmental public health governance structures and partnership models and provide recommendations to guide future discussions around improving population health of North Carolinians.

ii. Collaborate with the North Carolina Association of Local Health Directors, and/or other organizations as needed, to evaluate and provide a report on overarching themes and lessons learned from health departments that have partnered with health care entities in their communities to shift health service provision from health department responsibility.

Desired Result

Best practices for local public health governance, partnerships, and services will inform future innovations to best serve community needs.

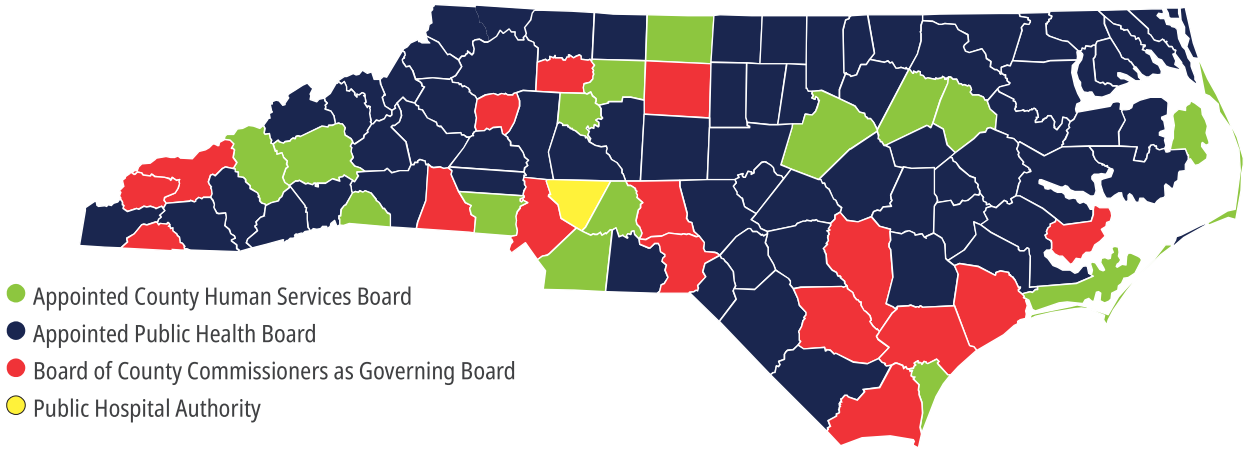
Why does the task force recommend this strategy?

The task force learned about and discussed examples of different governance structures, regional collaborations, and health services partnerships. Yet, objective evidence is not readily available to support our understanding of how these local or regional innovations have impacted health outcomes, or to identify specific facilitators and barriers to success. It is challenging to tease out the independent effects of one specific factor, such as the health department's governance structure, on a community's health outcomes or a local health department's performance. Therefore, analysis is needed to identify what is working and why.

Additional Context

Local health departments are governed by a board whose membership is dependent on the governance structure determined by each county. The North Carolina General Assembly passed S.L. 2012-126 in 2012 to give counties new options for how to organize and govern their human services functions. Specifically, this law "(1) allowed any Board of County Commissioners ("BOCC") in a county with a county manager to combine two or more human services functions into a single consolidated human services agency ("CHSA"); and (2) allowed any BOCC to directly assume the powers and duties of one or more of the governing boards responsible for overseeing a local human services agency (i.e., local board of health and/or county board of social services), including the board of a CHSA."[11] Therefore, across the state there are appointed Consolidated Human Services Boards, appointed Public Health Boards, and Boards of County Commissioners serving as Boards of Health (see Figure 15).[F] Depending on the type of board, some positions are required to be filled by people with specific credentials, training, or expertise. Boards are comprised of local leaders who have experience in sectors such as health care, dentistry, veterinary medicine, pharmacy, nursing, engineering, and other areas of expertise that align with public health responsibilities.[G] To date, there has not been an analysis of the operational effectiveness or health outcomes related to different forms of public health governance in North Carolina. This information could also be used to identify opportunities for increased flexibility in the membership composition for Boards of Health, a topic both the task force and other groups across the state have interest in addressing. Increased flexibility could allow for more diverse backgrounds and career experiences—particularly individuals with experience in and knowledge of addressing population and community health issues—to represent the unique needs of communities across the state.[H,I]

Figure 15. Local Public Health Agency Governance Structure



Source: UNC School of Government. Interactive Maps – Organization and Governance of NC Human Services Agencies. https://humanservices.sog.unc.edu/visualization-all/

[F] *Cabarrus County is unique in North Carolina as the only county that provides public health services through a Public Hospital Authority with an appointed Board of Commissioners, pursuant to uncodified legislation allowing it to do so, S.L. 1997-502, sec. 12.*

[G] *More information on the differences between types of boards, their authorities and their membership is available through the UNC School of Government at https://www.sog.unc.edu/resources/faq-collections/key-players-nc-local-public-health-local-boards-health.*

[H] *Perspective shared during Foundation for Health Leadership and Innovation listening sessions with local public health agencies and participants in Community Health Assessment processes to understand challenges and needs.*

[I] *Flexibility in Board of Health member composition would require changes to North Carolina public health statute.*

Similar to the variance in governance structures, health departments have a variety of approaches to fulfilling their responsibility under state statute to ensure health services are available for community members.[J] Some larger health departments have partnered with health care providers in the community to shift some of these services out of the health department itself. For example, Catawba County Public Health shifted child health, prenatal care, and child dental services to community partners as the pool of providers became more competitive and the health department saw that patients could be served reliably through other providers that wanted to serve patients enrolled in Medicaid.[12] Although these services are now managed by community partners, some are still provided within the physical health department building with the partners as contractors. While this partnership had a unique trajectory specific to the partners and geography involved, there are learning opportunities here for health departments that desire to assure that high-quality clinical services are accessible in their communities without serving as direct service providers themselves.

How would this impact the health of communities?

Determining best practices for governance, partnerships, and health services will allow health departments across the state to identify innovative solutions that may work for their communities and ensure that community members are served by an efficient and effective local public health agency.

Who is responsible?

- North Carolina Institute for Public Health

Who are the partners?

- UNC School of Government
- North Carolina Association of Local Health Directors

[J] *North Carolina General Statute § 130A-1.1*

Strategy 6c – Support Opportunities for Innovation

The North Carolina General Assembly should support innovation and efforts to address population health in local public health by:

i. Allocating funds to sustain existing and developing regional local public health capabilities in workforce, data, and communications and incentivize additional regional collaboration to realize opportunities for efficiencies across local public health jurisdictions.

ii. Supporting the development of rural safety net providers by filling the Medicaid coverage gap.

Desired Result

Health departments will have flexibility and funding to explore innovative partnerships, such as regional collaborations for shared services or partnerships to provide health services to community members.

Why does the task force recommend this strategy?

Cross-jurisdiction and regional collaborations can be effective ways to maximize resources and ensure access to specialized skills. Many small and mid-sized local health departments lack sufficient funding to support full-time positions that promote community health improvement, such as public health data analysts and public health communications specialists. Sharing personnel could help to ensure these capabilities are available to serve all residents of the state. The task force encourages financial support and technical assistance for these collaborations, which need time and coordination to develop.

On the local level, public health's capacity to serve the community as a whole could be enhanced through partnerships with local health care service providers, including independent medical, dental, and behavioral health practices, as well as health systems and hospitals. These partnerships could facilitate the transition from direct service provision to a role of assuring access is available through aligned partnerships for health departments that want to make this shift. This transition is possible for health departments when two conditions have been satisfied. First, health care providers must be willing and able to care for patients who have traditionally been served by the health department. The task force encourages the North Carolina General Assembly to fill gaps in Medicaid eligibility to help expand access to health care services across the state so that community health care providers, particularly in rural areas, will have a financially feasible path to providing care to lower income residents. Second, local public health initiatives to improve community health must be reliably funded and not dependent on cross-subsidization from clinical services revenue. The task force encourages the North Carolina General Assembly to increase funding levels to local health departments to support the fundamental roles and responsibilities of local public health (see Chapter 10, Strategies 7a and 7b).

Additional Context

The **Center for Sharing Public Health Services** has worked around the country with health departments of many shapes and sizes, and has identified some of the factors that result in successful shared services relationships, such as goal clarity, trust and relationships, senior-level support, and project management and communications skills.[13] When these elements are in place, health departments around the country have developed innovative new models of effective service delivery in such areas as immunizations, epidemiology, and environmental health.[14] There are several efforts underway nationally to better understand effective ways for health departments to cooperate across jurisdictions. The state of Washington conducted an extensive study of service delivery options for Foundational Public Health Services, seeking to identify "best fit" options that fall outside the traditional binary of either single-county responsibility or state responsibility. Washington State has categorized several forms of collaboration, including the "hub-and-spoke model" (locating specialized expertise and resources in several health departments throughout the state with formal agreements to support surrounding counties) and the "center of excellence model" (centralized expertise based in a local health department provides consultation across the state). A pilot project demonstrated that the center of excellence model proved to be a good fit for foundational public health services like control of tuberculosis, which is rare but serious and requires considerable expertise to provide up-to-date medical management.[15]

Sharing services across jurisdictions is also well underway across North Carolina. For example, the WNC Health Network in Western North Carolina and Health ENC in the Eastern part of the state provide support for multiple health departments to collaborate on a core public health function, the community health assessment. Participating counties pool resources for data collection and analysis, while local staff produce a county-specific report and work locally to foster multisector collaboration to address the priorities identified in the assessment.

The North Carolina law[K] that gave counties flexibility for the organization and governance of their human services functions (see Strategy 6a) also sought to establish a Public Health Improvement Incentive Program. The program was meant to "provide monetary incentives for the creation and expansion of multicounty local health departments serving a population of not less than 75,000."[16] However, no funds were allocated to the North Carolina Department of Health and Human Services to implement the program, and it was never established. Many county health departments participate in or express renewed interest in cross-jurisdictional resource sharing and other partnerships to improve capacity and effectiveness. This provides an opportunity for the General Assembly to encourage these partnerships and shared services across public health departments to streamline operations and serve as responsible stewards of public funding.

[K] *S. L. 2012-126*

To further improve local public health's ability to address issues affecting community health at the population level, health department capacity and resources dedicated to provision of individual health care services will need to be shifted over time. In larger communities, these health care services may be widely accessible to all members of the public through free and charitable clinics, federally qualified health centers (FQHCs), or hospital- and health-system-based clinics. However, task force members representing mid-sized and smaller communities often reported that their communities lack many health care services, and this reality remains a driving reason for health departments to provide clinical care themselves.

Task force members reported that reimbursement for clinical services, primarily from the Medicaid program, has historically provided a predictable and stable source of revenue for health departments. In many cases, revenue from clinical services is used to subsidize other functions of the health department and provides necessary baseline funds for community health education and other population-level projects. Recently, with the implementation of Medicaid managed care, there have been some disruptions in the reliability of this funding source. Preliminary estimates from the North Carolina Local Health Director's Association indicate that many health departments are dedicating additional staff to navigate billing settlements and are currently receiving a smaller percentage of funds from claims than they did prior to the implementation of managed care.[L] The NC Medicaid team, leaders from the prepaid health plans, and local public health leaders are working together to resolve these challenges.

The task force emphasizes that health departments in North Carolina must provide population-level public health services and must develop new significant, sustainable, and predictable revenue streams to fund productive community partnerships, data systems, and communications to promote health for all and eliminate inequities. The task force also recognizes that, in our current reality, some health departments must also provide clinical services in order for their residents to have equitable access to health care. However, health departments need stable sources of revenue that pay for the full cost of effective population-level programs without cross-subsidization from clinical services revenue, and North Carolina residents should ideally have access to multiple care options in their communities from a range of providers that they trust.

Filling the Medicaid coverage gap by increasing eligibility to 138% of the federal poverty level would have the short-term benefit to health departments of improving reimbursement for care provided to uninsured patients. In the long term, increased Medicaid coverage, particularly in rural areas, would encourage additional providers to establish care sites, potentially allowing health departments to transition away from health care service provision.[M] Increased Medicaid eligibility could help provide coverage to as many as 626,000 uninsured people, many of whom live in rural areas, with 20 of the 22 counties with the highest percentage of uninsured North Carolinians being rural.[17,18]

How would this impact the health of communities?

Collaboration between local public health agencies can enhance the quality of services and programs and improve the capacity of the local public health workforce to engage in additional activities geared toward improving the health of the community. Increased health insurance coverage through Medicaid would directly benefit community members who could then more easily access health care services, and also benefit the short-and long-term operations and mission of local health departments.

Who is responsible?

- North Carolina General Assembly

Who are the partners?

- Local health departments

[L] *Personal communication with Scott Harrelson, President of the North Carolina Local Health Directors Association and Health Director of the Craven County Health Department.*

[M] *Additional funding sources will be necessary to address the gaps in funding that would be created with decreased health care service provision. See Chapter 10 for additional discussion on funding sources for local public health.*

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