**Organization and Governance of Local Public Health & Other Human Services Agencies**
**Summary of S.L. 2012-126 (H 438)**

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During the 2011 and 2012 legislative sessions, the North Carolina General Assembly considered several bills that could alter the way county human services agencies are organized or governed. One of those bills was ultimately enacted—S.L. 2012-126 (H 438) became law on June 29, 2012. The new law:

- Creates new options for organizing and governing county human services agencies, by allowing a board of county commissioners to assume the powers and duties of certain boards, create a consolidated human services agency, or take both actions.
- Makes changes to the state law on consolidated human services agencies.
- Creates the Public Health Improvement Incentive Program to provide monetary incentives for multi-county local public health agencies serving populations of 75,000 or more.
- Attaches new conditions to state and federal funding for local public health agencies, including a new county maintenance-of-effort requirement.
- Rewrites the state's list of essential public health services and transfers responsibility for ensuring them from the state public health agency to local public health agencies.
- Requires the General Assembly's Program Evaluation Division to study the feasibility of transferring the North Carolina Division of Public Health to the UNC Healthcare System or the UNC School of Public Health.

## New Options for Organizing and Governing County Human Services Agencies

The new legislation extends to all counties some options that previously were available only to counties with populations exceeding 425,000. The options are:

1. Assume direct control of certain local boards by adopting a resolution abolishing the board(s) and transferring their powers and duties to the board of county commissioners;
2. Create a consolidated human services agency (CHSA) governed by a consolidated human services board appointed by the county commissioners; or
3. Create a CHSA governed directly by the county commissioners.

Option 1 is available to any county. Options 2 and 3 are available to counties with a county manager appointed pursuant to G.S. 153A-81.[1]

*Assuming direct control of local boards.* Under the new law, any board of county commissioners may assume the powers and duties of the local board of health, the social services board, or any other

[1] Every county except Tyrrell has a county manager appointed pursuant to G.S. 153A-81. Tyrrell is presently part of a three-county district health department.

commission, board, or agency appointed by the county commissioners or acting under and pursuant to the commissioners' authority—with a few exceptions. Amendments to G.S. 153A-76 prohibit county commissioners from abolishing and assuming the powers and duties of any of the following:

- An area mental health, developmental disabilities, and substance abuse services board.[2]
- A public health authority assigned the power, duties, and responsibilities to provide public health services as outlined in G.S. 130A-1.1.[3]
- A public hospital authority authorized to provide public health services under S.L. 1997-502.[4]
- A public hospital as defined in G.S. 159-39(a).[5]

If the county commissioners assume the powers and duties of the local board of health, the new law requires them to appoint an advisory committee with the same membership that presently is required for a county board of health: a physician, a dentist, an optometrist, a veterinarian, a registered nurse, a pharmacist, a county commissioner, a professional engineer, and three representatives of the general public. The law *permits* county commissioners that have assumed local boards' powers and duties to appoint other advisory committees as well, but the health advisory committee is the only one that is *required*. The requirement for an advisory committee on health does not apply to a county that delegates health board powers and duties to a consolidated human services board. However, if the consolidated human services board is abolished and the county commissioners assume its duties, the health advisory committee must be appointed.[6]

There are several types of local boards of health in North Carolina. Under the law and exceptions outlined above, a board of county commissioners may abolish and assume the duties of two types: a county board of health or a county consolidated human services board. The law does not permit county commissioners to abolish or assume the duties of a district (multi-county) board of health, a public health authority board, or a public hospital authority board assigned public health duties.

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[2] A grandfather clause provides an exception for Mecklenburg county. G.S. 153A-76(6).

[3] At present, Hertford county is the only county in North Carolina that has a public health authority (PHA) created under North Carolina's Public Health Authorities Act (G.S. Ch. 130A, Art. 2, Pt. 1B) and responsible for public health services under G.S. 130A-1.1 (as amended by S.L. 2012-126). However, this provision would also apply to PHAs that are created in the future. Another law, G.S. 130A-45.2, authorizes county commissioners to dissolve a PHA if the commissioners determine the authority is not acting in the best health interests of its service area. The new provision appears to conflict with that law, as it states that a board of county commissioners "may not abolish … a public health authority … ." G.S. 153A-76(5). However, it seems unlikely the legislature intended to alter the commissioners' authority to dissolve a PHA under G.S. 130A-45.2. Probably the intent of this provision was simply to prohibit a board of county commissioners from abolishing the *board* of a PHA and assuming the authority board's powers and duties.

[4] This provision applies only to Cabarrus county.

[5] G.S. 159-39(a) defines "public hospital" as a hospital that (1) is operated by a county, city, hospital district, or hospital authority; or (2) is owned by a county, city, hospital district, or hospital authority but operated by a nonprofit whose board of directors is appointed primarily by the owning entity; or (3) has a financial relationship with a city or county that involves outstanding bonds or current appropriations to the hospital.

[6] The requirement for a health advisory committee applies only to counties that abolish their health boards after January 1, 2012. This amounts to an exception for Mecklenburg county, which abolished its boards (a county board of health, and subsequently a consolidated human services board) before that date.

A board of county commissioners that wishes to exercise its authority to assume direct control of a county human services board must adopt a resolution "assuming and conferring upon the board of county commissioners all powers, responsibilities, and duties" of the human services board. Before adopting the resolution, the board of commissioners must hold a public hearing and provide at least 30 days' notice of the public hearing.[7]

S.L. 2012-126 also amends G.S. 153A-76, a law that addresses the authority of county commissioners to organize county government. Among other things, the law permits commissioners to change the manner of selection or composition of some county boards, but under prior law this authority did not extend to the boards of education, health, social services, elections, or alcoholic beverage control. The new legislation deletes the boards of health and social services from that list. The significance of this deletion is unclear. It may be that it is intended simply to clarify that G.S. 153A-76 does not impede the authority of commissioners to abolish those boards, or to create a consolidated human services board that would then take on the duties of those boards.[8]

*Creating a consolidated human services agency and determining how it is governed.* The new law extends the authority to create a consolidated human services agency (CHSA) to any county with a county manager appointed pursuant to G.S. 153A-81. A CHSA combines some or all of a county's human services functions into a single agency. Under prior law, it appeared that a CHSA was *required* to include three agencies: social services, public health, *and* mental health, developmental disabilities and substance abuse services (MHDDSAS). The new law authorizes a county to create a CHSA to "carry out the functions of any combination of commissions, boards, or agencies appointed by the board of county commissioners or acting under and pursuant to the authority of the board of county commissioners." It specifies that the CHSA may include public health, social services, *or* MHDDSAS, but it no longer must have all three, and it is likely most counties will not be able to include MHDDSAS in a CHSA.[9] Counties may also assign other county human services functions to the CHSA.[10]

There are some limitations to what may be included in a CHSA. Amendments to G.S. 153A-76 prohibit county commissioners from consolidating into a human services agency any of the following:

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[7] G.S. 153A-77(a).

[8] Local boards of health and county social services boards have separate statutes establishing their manner of selection and composition. G.S. 130A-35 (county board of health); 130A-37 (district board of health); 108A-3 (county social services board).

[9] Other changes to the law appear to exclude MHDDSAS from CHSAs. An amendment to G.S. 153A-76 prohibits counties from consolidating a MHDDSAS board into a consolidated human services board (but there is grandfather clause creating an exception for Mecklenburg county). There have also been a number of changes to the state's MHDDSAS system that have resulted in most counties being part of multi-county agencies, which could not be consolidated as they are not acting under or pursuant to the authority of any one county's board of commissioners.

[10] The law does not specify which other functions may be included, nor does it give an illustrative list. It appears that any county human services activity could be included. The term "human services" is not defined in the law. The types of activities that are carried out by North Carolina's state human services agency include social services, public health, MHDDSAS, medical assistance (Medicaid), aging services, services for the blind and deaf, child development, health services regulation, and rural health and community care.

- A public health authority assigned the power, duties, and responsibilities to provide public health services as outlined in G.S. 130A-1.1.
- A public hospital authority authorized to provide public health services under S.L. 1997-502.
- A public hospital as defined in G.S. 159-39(a).

The CHSA law provides that a CHSA is governed by a consolidated human services board, which is appointed by the county commissioners. The board has particular membership requirements and is assigned specific powers and duties.[11] The new legislation still provides for this structure, but it also permits county commissioners to abolish the consolidated human services board and assume its powers and duties.[12] Therefore, under this new legislation a county with a county manager appointed pursuant to G.S. 153A-81 may create a CHSA governed by a consolidated human services board, or it may create a CHSA governed directly by the county commissioners.

What does this mean for public health? In North Carolina, each county has the duty to provide public health services.[13] This duty was not created or changed by the new legislation, but the menu of choices for how those services may be organized and governed has changed for most counties. A county may provide public health services through a county health department, a multi-county district health department, a public health authority, or a consolidated human services agency.[14] If a county operates either a county health department or a consolidated human services agency that includes public health, the agency may be governed by a board appointed by the county commissioners, or it may be governed directly by the commissioners upon adoption of a resolution assuming the powers and duties of the agency's board.

Additional changes to CHSAs

The new legislation makes several other changes to the CHSA law, primarily relating to the agency's board and its employees.

*Board.* First, S.L. 2012-126 appears to alter the composition of the board for a consolidated human services agency that does not include MHDDSAS. Such a board would be required to include four consumers of human services.[15] Second, it removes the requirement that that a consolidated human

[11] G.S. 153A-77(c) & (d).
[12] G.S. 153A-77(a). Before abolishing the CHSA board, the county must give at least 30 days' notice of a public hearing and hold the public hearing. *Id.*
[13] G.S. 130A-34(a).
[14] G.S. 130A-34(b); 130A-45.1. A county may also contract with the state to provide public health services within the county. G.S. 130A-34(b). No county has operated under this type of arrangement for several decades.
[15] G.S. 153A-77(c). The law as amended is unclear. It retains a provision that requires a CHSA board to have eight consumer members, six of whom are consumers of MHDDSA services. The new provision requiring four consumers of human services includes a "notwithstanding" clause that suggests the intent was to create an alternative membership for a CHSA board that does not include MHDDSAS. The new provision does not specify which human services the four consumer members must represent.

services board perform comprehensive mental health planning, if the consolidated board is not exercising the powers and duties of a MHDDSAS board.

*Employees.* S.L. 2012-126 requires the director of a CHSA to appoint an individual that meets the statutory minimum education and experience qualifications for a local health director.[16] The county manager must approve the appointment. This new provision does not specify a role for the appointee, so it appears that the powers and duties of a local health director remain with the CHSA director. However, the CHSA director could delegate those duties to the appointee.[17]

The new law amends G.S. 153A-77(d) to require consolidated human services agencies to have merit personnel systems that comply with any applicable federal laws. It also authorizes county commissioners to elect to make CHSA employees subject to the State Personnel Act.

Public Health Improvement Incentive Program

Section 3 of S.L. 2012-126 enacts new G.S. 130A-34.3, which creates the Public Health Improvement Incentive Program. The purpose of the program is to provide monetary incentives for the creation and expansion of multi-county local health departments serving populations of 75,000 or more.[18] The new statute directs the North Carolina Commission for Public Health to adopt rules implementing the program.

It is unclear how the Public Health Improvement Incentive Program will be funded. There was no appropriation for the program in the final state budget bills.[19] Earlier versions of House Bill 438 included an allocation of funds for the program, but the allocation was eliminated before the bill was enacted.

Other Public Health System Changes

*Conditions on state and federal funds.* The legislation also enacts new G.S. 130A-34.4, which conditions the provision of state and federal funds to local public health agencies on two criteria:

- The local public health agency must obtain and maintain accreditation under North Carolina's existing local health department accreditation law (G.S. 130A-34.1),[20] and

[16] G.S. 130A-40(a). In general, a local health director must have a background in medicine, public health, or public administration related to health services.
[17] See G.S. 130A-43(c) (giving a CHSA director most of the powers and duties of a local health director); 130A-6 (allowing an official with authority granted by Chapter 130A to delegate that authority to another person).
[18] Presumably the multi-county agencies could be either district health departments or multi-county public health authorities. The program does not appear to apply to single-county agencies of any type, regardless of the population served.
[19] S.L. 2012-142 (H 950); 2012-145 (S 187).
[20] The Appropriations Act for FY 2012-2013 eliminated funding for the NC Local Health Department Accreditation Program. S.L. 2012-142 (H 950); see also *The Joint Conference Committee Report on the Continuation, Expansion, and Capital Budgets* (June 20, 2012), page G-9 (available at http://www.ncleg.net/sessions/2011/budget/2012/Conference_Committee_Report_2012-06-20.pdf). However,

- The county or counties comprising the agency must maintain operating appropriations to the local public health agency at levels appropriated in state fiscal year 2010-2011.

Local agencies must meet these criteria by July 1, 2014 to remain eligible for funds. The proportion of a local public health agency's budget that comes from state and federal funding varies by agency, but the amount ranges from about one-fifth to about one-third of the agency's total budget (not including Medicaid payments, which are not affected by the condition imposed by this provision).[21]

*Essential public health services.* Section 4 of S.L. 2012-126 amends G.S. 130A-1.1 to make local public health agencies responsible for ensuring that essential public health services are available and accessible to the population in each county served by the agency. Under prior law, the state was responsible for ensuring that essential public health services are available and accessible throughout the state. The legislation also rewrites the essential services to match the list presently used in the state's local health department accreditation law (G.S. 130A-34.1), which reflects a nationally recognized list of ten essential public health services.[22]

*Study DPH transfer to UNC.* Finally, S.L. 2012-126 requires the General Assembly's Program Evaluation Division to study the feasibility of transferring all the functions, powers, duties and obligations of the North Carolina Division of Public Health to the UNC Healthcare System and/or the UNC School of Public Health. The Program Evaluation Division must report its findings by February 1, 2013.

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another statute (G.S. 130A-34.1) and now this new law require local public health agencies to be accredited through the state program. As of this writing, the state accreditation program is expected to continue with funding from the local health departments, but the mechanism for funding the program has not yet been worked out. On July 1, 2012, 69 of the state's 85 local public health agencies had been accredited through the state program and a schedule was in place to assess the remaining agencies for accreditation by July 1, 2014. Accreditation status expires after four years, at which time an agency must be re-accredited.

[21] See *Comparing North Carolina's Local Public Health Agencies: The Legal Landscape, the Perspectives, and the Numbers (Issue Brief)*, page 5 (available at http://www.sog.unc.edu/node/2258).

[22] See http://www.cdc.gov/nphpsp/essentialServices.html. The list of essential public health services that formerly appeared in G.S. 130A-1.1. pre-dated the national list and was similar but not identical to it.