Appendix B

Perspectives of Stakeholders: Comprehensive Findings

This supplement presents the comprehensive results of focus groups and key informant interviews that were conducted to gain an understanding of stakeholders' perceptions of North Carolina's different organizational/governance models for local health departments (LHDs). Four focus groups were held, two with randomly selected health directors and two with randomly selected county officials (commissioner members of boards of health, county managers, or their designees). Individual key informant interviews were conducted with 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 (NCACC), and representatives from the UNC Gillings School of Global Public Health who work closely with local health departments. A total of sixty-four individuals participated in this component of the study.

Participant responses are categorized into two groups—public health practitioners and county officials and state legislators. **Practitioners** include current and former local and state health practitioners and current and former staff of the UNC Gillings School of Global Public Health who work (or worked) closely with LHDs. **Officials** include county managers, assistant county managers, county commissioners, NCACC representatives, and state legislators.

Tables of Results

Abbreviations

BOCC	Board of County Commissioners
BOH	Board of Health
CHD	County Health Department
CHSA	Consolidated Human Services Agency
DHD	District Health Department
LHD	Local Health Department
PHA	Public Health Authority

County Health Departments: Benefits

	Views of Practitioners	Views of Officials
Finance	• Tend to receive greater county financial contribution than some of the other models (DHDs/PHAs) • In seeking grants, target area/population (i.e., the county) is clearly defined • CHD is part of county government; can fall back on county if a cash flow issue arises	• Ownership of public health by county creates propensity for greater financial support, financial oversight, and advocacy from county officials (as compared to DHD or PHA) • Appropriate model for counties that can afford it
Workforce	• Employees are dedicated to public health; have a clear mission • Health director is required to meet minimum education and experience requirements	• Dedicated, committed staff
Service Delivery	• Close to the grassroots; can identify local needs and target programming to meet those needs • Empowered with a single focus—to promote public health; services are visible in the community • Good model for preparedness; CHD can readily partner with other county responders, such as social services	• Can identify local needs and tailor services to meet them • Allows public health to have a physical presence in the community (services and leadership); important for public to be able to "feel and touch" the significant public health responsibilities that are defined in law
Management & Governance	• Responsibility and accountability is shared among health director, county manager, and county commissioners • Health director only has to manage one set of relationships (one BOCC, county manager, BOH, etc.); decision making can be quicker, more efficient • BOH's sole focus is health of the community • BOH provides a way for a diverse set of health professionals to have input, so health policies are better • BOH depoliticizes decision making around health; BOH makes decisions on basis of good science and resists political bias • For politically sensitive policies and decisions, BOH provides a buffer to the BOCC, health director, and CHD staff • BOH members can communicate policies to and gain the support of their profession ("peer education"—physician to physician, veterinarian to veterinarian, etc.)	• County manager can work with health director and other department heads to create an overall "county vision of services" (more difficult to achieve with DHD/PHA models) • Can collaborate easily with other county agencies (e.g., schools, social services) to deliver services, because all agencies serve the same population • BOH structure with mandated positions provides a good representative base of professional expertise • BOH provides good oversight and direction • BOH has a high level of accountability, because BOH members live in the community and are the face of public health • BOH can assist with grant writing, accreditation

County Health Departments: Challenges and Concerns

	Views of Practitioners	Views of Officials
Finance	• Concern that the CHD model (relying on county contribution) may not be financially sustainable, especially for small counties that do not have the tax base to support CHD • Funding is variable county to county and dependent on local resources as well as value placed on public health by county officials; financial support can also change (up or down) over time within a county with changes in BOCC	• Finances/cost a big concern in small counties
Workforce	• Small, poor, rural counties have a hard time attracting and retaining staff, including a strong health director • Staff in small counties are stretched over many different jobs • Some CHDs can't afford to fully utilize specialized staff	• Small counties have trouble recruiting and keeping staff, especially physicians, nurses; compete for staff with other counties that can pay better • Staff in small counties wear multiple hats and are subject to burnout, resulting in high turnover
Service Delivery	• Variable quality and quantity of services from CHD to CHD (dependent on resources, leadership) • Smaller health departments struggle to provide core services • Concern that CHD does not have access to service/resources that exist in neighboring counties unless they officially partner	• Small counties are limited in what services they can provide because of lack of resources
Management & Governance	• Subject to local politics and personalities; amount of responsibility/authority health director has varies by county and is dependent on county manager, BOH, and BOCC; can also be variable in same county over time as individuals in these positions change • Not nimble; can become bogged down by bureaucracy and can't partner easily/quickly to take advantage of new opportunities (e.g., partnering with hospitals on community health assessments) • Composition of local boards of health might not be in public health interest but rather in interest of the professions (to maintain and safeguard their interests) • Can be a challenge in small counties to fill mandated BOH positions	• Challenging for county manger to have CHD employees fall under a different set of personnel policies (State Personnel Act) than other county employees • Concern that BOH has too much authority; county manager and commissioners' authority to use their expertise in public administration to impact CHD on an operational level (e.g., address operational inefficiencies, personnel issues) is limited • Link between authority and responsibility can be weak; when public has an issue with CHD, they appeal to BOCC, but BOCC has limited ability to intervene • Extremely difficult to remove members of BOH before term expires • Can be a challenge in small counties to fill mandated BOH positions

District Health Departments: Benefits

	Views of Practitioners	Views of Officials
Finance	• Spreads costs over a larger operation • Can bring in multiple revenue streams that can support public health (e.g., home health, hospice) and lower county contribution • Can carry a fund balance that can be reinvested in DHD; can be used to offset some costs associated with being a DHD, such as need for compatible information technology across counties	• Makes sense if county cannot do it alone financially; eliminates overhead and burden of a small struggling health department • Can save money (spread administrative costs over a larger operation) • Can reduce per capita cost to the county
Workforce	• Can afford higher salaries that can attract and retain qualified staff, including health director • Can afford specialized staff that a CHD can't afford or fully utilize but that several counties can afford and can keep busy (e.g., physician, grant writer)	• Might attract better staff • Can share staff among small counties
Service Delivery	• Smaller counties can have more and higher quality services than they could provide separately • Can still program for local needs by providing core services in all counties and specialized additional programs in some counties based on community needs and desires	• Effective way for small counties (that do not have the resources to run their own health department) to provide quality services
Management & Governance	• Health director has more responsibility and authority • More flexibility in hiring, contracting, and procurement; this flexibility makes DHDs more attractive partners to private and non-profit entities • Might provide more insulation from local county politics • District health board has similar benefits as county BOH • Because district board is focused solely on public health and has both policy and financial decision-making authority, it can be more action oriented • Because there are multiple county commissioners on a district board, they can be more willing to take action (e.g., adopt a resolution), since responsibility is spread over a group of commissioners, whereas on a county BOH, there is only one commissioner who may prefer to act as liaison to BOCC rather than make decision on his/her own	• Larger DHD board can provide equal representation of all counties in the district

District Health Departments: Challenges and Concerns

	Views of Practitioners	Views of Officials
Finance	• Counties provide significantly less funding to DHDs; concern that counties are not paying their fair share • Need for other revenue streams to supplement public health (i.e., need for a "moneymaker"); challenge to operate a DHD in an area where these streams do not exist • Concern that if DHD carries a fund balance, counties may want to lower their contribution • Concern that better resourced counties will have their health dollars spent outside their county in less resourced counties • Can be difficult to get all counties in district to agree on financial matters (e.g., per capita contribution, permit fees)	• Concern that counties in a district do not contribute enough funding and do not have enough "skin in the game"; should be held to a minimum level of funding • Concern that county loses ownership in district arrangement and eventually contributes less county money • Concern that unequal financial contributions from counties in the district might lead to a "race to the bottom" where one county lowers its contribution and then other counties lower theirs in response; becomes a "competition" to have lowest county contribution • Concern that smaller county would lose out in a district with bigger counties; "money follows the population"
Workforce	• Requires a health director who is entrepreneurial and has business management skills • To be successful, employees must view themselves as part of an integrated district with a shared mission and not as a group of independent counties with a single leader	• Might lose the personal touch health director and staff have with community members
Service Delivery	• Challenge of providing services to meet local needs could be magnified if mandated new districts merged counties with significantly different demographics and needs • Providing services in an emergency could be a challenge if several or all counties in the region are affected	• Counties have different demographics and different service needs • Concern that services would not be provided directly in every county • May not be any more effective in providing services than CHDs sharing the delivery of specific expensive services
Management & Governance	• Health director has to manage multiple sets of relationships in each county (multiple county managers, BOCCs); requires more time, energy, skill • Concern that district could split apart if one or more BOCCs becomes unhappy with the arrangement for any reason • District board members can become concerned with benefits to their specific county; challenge for health director to communicate to board members that "equality" in a district does not mean duplication of services everywhere	• Can't have a true "county vision of services"; have to worry what other counties in district think is important • Loss of local control/input; DHD is a step removed from the county • Loss of local (county) health director and ability to hire/fire that person within the county • County could lose ownership of public health as a core county service and public health could fall into a no man's land where no one is taking responsibility (example of mental health reform going awry and some counties feeling, "that's really not our concern anymore") • Concern that it would be difficult for public health to collaborate with other county partners if the health director "sits three counties away" and is unknown to county partners • Size of district BOH might be too large

Consolidated Human Services Agencies: Benefits

	Views of Practitioners	Views of Officials
Finance	• Potential to create efficiencies at the administrative level by combining human resources, billing, and other units of human services agencies • There is some overlap in clients of public health, social services, and mental health; can save money by eliminating duplicative services	• Can save money by combining administrative functions (human resources, finance, information technology) of human services agencies • Can potentially eliminate a high level salary by combining positions of health director and social services director • Do not necessarily need to add cost of a human services director; could have public health and other division directors report to county manager
Workforce	• Provides an opportunity for shared leadership; can have people with different expertise manage different divisions of CHSA • Can maintain a health director who can be the face of public health • Can cross-train staff	• Can cross-train staff for better customer service and succession planning • Might be able to provide same services with fewer staff
Service Delivery	• Can be an effective way to integrate service delivery (e.g., integrate public health messaging into social service delivery) • Integrated service delivery embraces a broad definition of health (physical, social, and emotional well-being) and has potential to meet the comprehensive needs of people	• Potential for integrated services to result in better outcomes • Might eliminate duplication of services • Co-locating human services agencies can make services more accessible to clients, as clients overlap • Less stigma for clients using services when building offers a wide range of services
Management & Governance	• Ability to quickly shift resources (human, financial) in an emergency • Opportunity for division directors to work together to prioritize use of financial and human resources (though a challenging and time-consuming process, incorporates many viewpoints into decisions)	• Makes lines of authority clearer and similar to other county departments; health director reports to county manager • All county employees can be under same personnel system; county manager can hire/fire health director • Can instill a "county vision of services" (can achieve this more readily when all departments are under same supervision and oversight) • Through process mapping (mapping the steps of service delivery for all services from beginning to end), can identify both where duplications lie and where opportunities for collaboration/integration exist

Consolidated Human Services Agencies: Challenges and Concerns

	Views of Practitioners	Views of Officials
Finance	• Only two CHSAs exist in the state; do not have data to know if perceived cost savings are real; might look good on paper but what is the reality? • Do not necessarily save on top salaries if there is a human services director in addition to assistant directors for public health, social services, and mental health (positions likely needed in all but smallest counties) • Concern that public health's prevention role will not compete well for funding with crisis intervention role of social services and mental health	
Workforce	• CHSA is too big to fail and complex, and therefore leadership is critical • Difficult to find people with appropriate background (training/experience in all disciplines and in integrated service delivery) to effectively lead the organization; will be especially difficult to attract qualified individuals to small counties • If a human services director with minimal public health experience/knowledge/passion is hired to lead the organization, he /she could reduce or dismantle public health services	• Concern that counties will have difficulty attracting a leader with needed skills, experience, and knowledge across disciplines; especially true for small counties • Concern that in small county, public health and social services staffing is already lean and specialized and merger might require more rather than less staff • Ability to cross-train staff will have limits based on credentialing requirements of certain positions (e.g., nurse practitioner)
Service Delivery	• Perception that of clients of public health, social services, and mental health are the same, but they are not; may be overlap, especially for LHDs that offer clinical services, but overlap is very limited • Unit of service and mission are different; public health serves the entire population and is focused on prevention, whereas social services and mental health are focused on subpopulations and provide crisis intervention services • Challenge of effectively integrating services is impacted by numerous restrictions and requirements (e.g., client eligibility) of different state and federal funding streams • Visibility of public health might be reduced	• Integrating services is a challenging process; have to consider restrictions and requirements of different funding streams • Concern that public health could lose visibility • Concern that clients might have to navigate a larger bureaucracy

Consolidated Human Services Agencies: Challenges and Concerns
(Continued)

	Views of Practitioners	Views of Officials
Management & Governance	• Current CHSA model allows county manager to hire/fire human services director, and employees are subject to county personnel systems rather than State Personnel Act; model seems focused on expanding local control • State Personnel Act protects against political hiring and that would be lost with CHSA model • Human resources and finance ("people and money") are critical management tools; if health director cannot directly manage these (because they become centralized), his/her effectiveness is marginalized; work all gets put in one big CHSA stack; process is slower and less responsive • Health director might have less direct access to BOCC to discuss issues or make requests (has to go through assistant county manager and/or county manager) • Integrating the information technology systems of public health, social services, and mental health will be a major challenge and will likely be costly • Working across divisions, programs, cultures is a challenge • Concern about complexity of CHSA model and ability of consolidated human services board or BOCC to make effective decisions; decision makers will need knowledge of rules and regulations of public health, social services, and mental health • Concern about size of consolidated board; if subcommittees act like separate boards, will defeat the whole purpose of having a consolidated board • Concern that public health decision making can become diluted on a consolidated board	• Mission/professions are different; challenge of working across boundaries and cultures; could "open up a can of worms" • Getting buy-in from all agencies and their boards to create a CHSA will likely be difficult • Have already streamlined public health and social services and eliminated duplications so do not see added benefit

Public Health (and Hospital) Authorities: Benefits

	Views of Practitioners	Views of Officials
Finance	• Takes financial pressure off the county; can allow county to control its public health costs (e.g., if it agrees to fund the PHA at a set per capita rate) • Flexible and nimble systems can enable PHA to obtain funding from multiple sources to support public health • If a per capita county contribution can be negotiated, PHA can experience growth in community without having to reduce services	• Allows for flexibility in bringing in revenue • Can save county money
Workforce	• Increased flexibility in hiring (do not have restrictions of State Personnel Act or county personnel system) • In an emergency, can quickly bring in extra staff • Have staff or can find resources to support grant writing	
Service Delivery	• More flexibility in providing services that meet local needs • Not bound by political and geographic county lines; can serve clients from outside county	• Focused solely on public health
Management & Governance	• More autonomy and independence from county; PHA has a degree of separation from close oversight by county that allows for creativity/innovation/nimbleness in overall management • Increased ability to partner with organizations that might not otherwise want to partner with a bureaucratic government agency or with one that can only provide services within a specific jurisdiction (i.e., county) • Independence from county can be an advantage to BOCC; can distance themselves from unpopular public health decisions and policies • PHA board has more opportunity to adopt health policies and rules because they are even more removed from politics than traditional BOH	• More autonomy

Public Health (and Hospital) Authorities: Challenges and Concerns

	Views of Practitioners	Views of Officials
Finance	• Concern that county support (funding/infrastructure) is reduced; concern that county contribution would be low, similar to a DHD • Concern that PHA would be challenged to survive in a county that has a shrinking population (overall county contribution decreases if it is per capita based) or if there are no opportunities in the county to generate revenue (no "moneymakers")	• Concern that if PHA runs into financial problems or fails, county will be responsible for fixing it • Concern that it is too expensive to be an authority (e.g., could they afford to hire their own attorney?) • Challenge of funding—if PHA negotiates a county contribution up front, how does it later revisit that when circumstances change
Workforce	• Requires a health director who is innovative, entrepreneurial, and can manage a business; must be willing to take risks	• Requires leadership with the ability to bring in funding; is entrepreneurial
Service Delivery		• Could raise fees (e.g., permits) in ways that may hurt customers
Management & Governance	• Challenge to get started; requires support of BOCC, extensive planning and development of systems, and strategic positioning as PHA will have to compete with other healthcare providers • In launching a PHA, can have an uphill battle with staff who have concerns about benefits and leaving state personnel system • Need more information on what it would cost to move to this model; how much start-up money is needed and how does it work financially • Because PHA does not need permission to provide services outside of its county, there is the challenge of being politically sensitive to neighboring counties (when providing services in their jurisdictions) so as not to create conflict	• Separates governance from the people elected; citizens have no recourse if they are unhappy with the authority • Loss of local control/input; public health becomes a contracted vendor service versus a core county service; counties become disenfranchised • Concern that PHA would be an island unto itself; cannot rely on the overall county infrastructure the way a CHD can

Board of County Commissioners as Board of Health: Benefits

Views of Practitioners	Views of Officials
• Do not see a benefit • Potential for commissioners to become more familiar with public health and for health director to have more direct connection with BOCC • If the county commissioners delegate duties to a subgroup of commissioners with an interest in and knowledge of public health, "it can go OK"	• Potential for more accountability and transparency; elected officials can be held directly accountable for quality of public health services delivered • Would work fine in some counties and wouldn't in others (to be successful, BOCC would need to understand statutory public health mandates, that public health service delivery is a core business of the county, and that public health is not synonymous with clinical services) • An advisory committee of health professionals could provide expertise to BOCC, but it is not necessarily best for technical people to govern a department • Having BOCC as sole board can speed decision making and implementation ("one group that understands everything") • Check and balance to BOCC making politically influenced health policy decisions can be county manager; county managers are members of International City/County Management Association (ICMA) and have a strong code of ethics that requires objective, nonpartisan decision making • Removes an institution that has diminished relevancy; BOH was a good model for last century when there was more health risk, but now federal, state, and county regulations take care of a lot of the problems BOHs used to address; in addition, much of the expertise of the BOH members can be found in the health department staff

Board of County Commissioners as Board of Health: Challenges and Concerns

Views of Practitioners	Views of Officials
• County will lose the professional health expertise of BOH; not all commissioners have the expertise to make public health policy • BOH operates predominantly on basis of good science and resists political interference in decision making; could inject partisan politics into public health decisions, especially in swing counties • BOCC more likely to make public health decisions based on factors in addition to health; might not always think about what is best for public's health, but what's good for a particular constituent • Commissioners have to face the electorate every two to four years and are not in a position to make tough calls around health policy; a lot of permitting and inspection falls under public health—will have to make decisions that are not popular with individual citizens • BOH serves as buffer for unpopular public health decisions; BOCC would lose this • BOH can allow political protection to do what is needed in an emergency (e.g., isolation and quarantine during H1N1, closing local restaurants if there is some kind of contamination) • BOCC already has a varied and full agenda; putting too much on their plate; might end up delegating, so why not delegate to a trained BOH • Takes time for new BOH members to get up to speed on public health laws, rules, and policies and become functional; could be even more of an issue if BOCC is BOH, because commissioners can be more susceptible to turnover (could have a wholesale sweep with an election) • North Carolina accreditation standards are written around structure of appointed BOH; might be hard to get commissioners to do the things necessary to meet accreditation standards given all their other responsibilities • Putting a lot of power in very few hands • Potential of more dictates (from BOCC to LHD) and danger of health director being hired/fired for political reasons • BOH is part of a system of checks and balances; this would be lost if BOCC assumes powers and duties of BOH	• Expertise on BOH provides a mechanism for understanding how policy decisions will play out in the real world; concern that abolishing BOH is "throwing out the baby with the bathwater" • While BOCC members have intelligence and integrity, they do not necessarily have public health knowledge/expertise; would lose professional health expertise found on BOH • Citizen board has value; while BOHs are not directly accountable to the public (public cannot vote out BOH members), there are some areas where a buffer is needed; for example, the board of education protects superintendent of schools from angry parents, and the health director and health department may need the same buffer • Public health decisions (especially around environmental health) might become politicized; BOCC could make decisions based on politics rather than science • Commissioners might make decisions that are purely money driven • Commissioners would spend more time "in the weeds" on public health issues and less time on big picture, county-level, strategic planning; would bog down BOCC agenda; would require full-time county commissioners and most are part-time • By the time BOCC was acclimated to what was going on in public health, their terms would be over and "you'd have a new bunch in to train" • Danger of health director being hired/fired for political reasons • Many county commissioners are not interested in public health (have different interests like sheriff's department or fire department)

Reasons Stakeholders Would Consider Changing Models

Views of Practitioners	Views of Officials
• To stay relevant—as healthcare system changes and patient demands change, clients who never used public health are now using services • To do more than survive as a health department; prosper and grow • To increase access to resources • To improve health outcomes • To improve operational efficiency • To have more flexibility • To improve services	• To save money; achieve economies of scale • To be able to remove employees from State Personnel Act • To make lines of authority similar to other county departments—health director reports to county manager • If the change has a financial incentive (from the state) associated with it • If finances continue to dwindle, would consider regional opportunity • If regional opportunity would enable county to cut overall costs or reduce per capita costs, would consider it • If there were data showing another model saved costs while providing same level of service, would consider it • If a regional opportunity presented itself, would be motivated to consider it because regional cooperation has worked for the county in other areas • If there were complaints from the public, would consider making change • Would only consider consolidation if mandated by state; would prefer state to set service goals and give counties flexibility in how to reach those goals

Advice from Stakeholders on Changing Models

Local and state stakeholders who have direct experience with DHDs, CHSAs, or PHAs, or who have considered changing to one of these models, offered the following advice to other stakeholders who may be considering change. *This advice is not necessarily endorsed by the UNC School of Government*.

Becoming a DHD	• DHDs function best when composed of counties that are similar in size, resources, culture and that have a history of collaborating regionally in other areas • Some neighboring counties get along well and some do not; need to understand the cultural and political environment of counties, as well as historical alignments, to assess whether or not a successful district can be created • Anticipated financial savings may not be immediate when forming a new district; need to build and pay for infrastructure such as information technology and transportation • Communication technology is extremely important when stretching out geographically • Need to consider size of district; economies of scale can be lost if district becomes too big • Health director needs to make sure county officials and public don't see the DHD as different from other county departments • Need to sort out many operational issues before joining together; for example: – What will each county contribute financially? – How will different county fund balances be addressed? – How will different revenue streams be handled (e.g., if one county has home health revenues and others do not)? – How will personnel issues (health insurance, benefits, longevity) be handled?
Becoming a CHSA	• Consolidate for the "right reasons"—to create an integrated system of care, *not* to cut budgets or address conflict between county officials and human services officials; philosophical alignment of county manager, BOCC, directors, and their boards is critical to success of CHSA • Make sure you are designing a system that meets the needs of consumers and that you gather community input before making any change • Takes time—years, decades even—to transition to a CHSA that is able to work across departmental/program boundaries to achieve desired outcomes; people want a quick win and it doesn't happen that way; leadership needs to be invested for the long haul • Process of reorganizing has a cost—to staff and to taxpayers • Need to have compatible information technology in place (or a plan to develop it) • Even if services/programs are integrated, important to have someone own it and have ultimate responsibility • Get baseline data before becoming a CHSA and then study the change to evaluate impact on cost, services, and outcomes
Becoming a PHA	• Transitioning to this model takes time (approximately eighteen months) and requires a great deal of planning and education • Important to invest time educating BOH, BOCC, and other stakeholders about how the new structure will work and what the benefits will be • Critical to address how new structure will impact personnel benefits of current staff • If a per capita county contribution is negotiated, it can enable the PHA to experience growth in the community without having to cut services • Put agreements between county and PHA in writing (especially funding agreements) • Once PHA is operational, keep BOCC informed of activities

Open-Ended Comments from Public Health Practitioners

- Be clear about what you perceive is broken in the current model that is moving you to another model, and be clear about what support you will have.
- Change should be rolled out systematically; conduct a readiness assessment; pilot change; get baseline data and then study change to evaluate impact on costs, services, and outcomes.
- Leadership is what makes or breaks the model that is in place; it's not a new model that is going to fix a county's problems, but leadership.
- When you make change, there is always a trade-off. You will gain some and lose some. Need to participate in shaping change even if you don't like it.
- Change needs to bubble up from the bottom; change does not work well when it is forced and people do not buy into it.
- Change needs to take place from the top down; needs to be guided by an overarching vision.
- County officials are motivated to make change because of conflict with their health director or dissatisfaction with a particular program or something health department has done; public health needs to better communicate what a health department is required to do, and what it is not required to do, and what impact the health department has on the community.
- Health directors need to maintain a close working relationship with county managers and commissioners to understand where their pressures come from and to help solve problems when they are in their early stages.
- Public health needs to demonstrate the value of public health to county officials. Need to make link between a healthy community and economic development (e.g., businesses do not want to come to communities with high obesity rates; don't want to draw employees from a community that is going to cost them a lot in healthcare). Need to make link between public health and education (e.g., link between early childhood development programs and graduation rates). Need to enlist partners in demonstrating value of public health. Need to demonstrate that public health is accountable (e.g., through accreditation, health indicators).
- Models that reduce county control (DHDs and PHAs), if left to the decision of county commissioners, are unlikely to be adopted.
- Financial incentives work; need to keep these incentive funds in a separate pot so it remains clear over time that extra money is for a specific purpose (i.e., you get more money because you agreed to be a district; if you stop being a district, the money goes away).
- Accreditation was not the incentive to create districts that some thought it would be.
- Should be reassessing the overall public health system, rather than shifting among models.
- Have been having conversation for years about best way to organize, provide governance; important to recognize the system you are working in and how you can leverage resources and people in the most effective way to get the results you want regardless of the structure you are in.
- System needs to adjust to the market and economic environment of the time; given all the changes going on nationally with healthcare reform and the resurgence of federally qualified health centers (FQHCs), local public health needs to carve out its niche.
- Come up with a target or benchmark for county per capita contributions—"this is what it costs to provide the services that need to be provided."
- Need a minimum size population for health departments.
- There is a huge challenge with the number of health departments in the state; regionalization makes sense.
- State would be better served by regional health departments under state control.
- If districts are formed, should be created by a neutral body based on population, distance, and other criteria.
- Need to revamp accountability system; there are too many consultants for the various federal programs administered by the state; waste time and money.
- Local health departments need more flexibility with regard to how state/federal funds can be spent; base spending on needs of community.
- Need a cabinet level state public health department that has a secretary that is part of the governor's cabinet and has access to the governor on a regular basis.
- Need stronger leadership from NCDPH, but don't know that we need all the personnel; do not need such a large department in a decentralized state.

Open-Ended Comments from County Officials and State Legislators

- Let local communities decide how they want to organize; allow for flexibility and choice.
- Need realistic information on the different models.
- Need a mechanism for county manager to insert himself or herself into health department operations when something is not serving the community well.
- Implement change slowly or through pilots; evaluate change.
- Get buy-in from all parties before implementing change.
- Be very careful in any kind of restructuring where ownership is not retained by the local community.
- Learn the lessons of mental health reform.
- Desire for change—on county side—often originates with county manager. "Whatever their vision about their day-to-day work . . . and how it needs to be fixed is what has been handed to the commissioners. So that's how they feel about it."
- State would be best served by regional (multi-county) human service agencies; having too many health departments and social services agencies ends up focusing funding on overhead and not service delivery.
- Don't stir a pot that does not need to be stirred; North Carolina is on the right path.
- Recession is not ending any time soon; need to create a leaner health department that can provide essential services.
- Would like to see more integration of theory and practice—collaboration between UNC and locals, with ideas and best practices flowing in both directions.
- When Affordable Care Act kicks in, will be many more people on Medicaid; need to prepare for impact on social services and public health.
- Concern that offering financial incentives for regionalization penalizes single-county health departments: "We're not going to get any help unless we regionalize."
- Move substance abuse sections of mental health to public health.
- Would like to see more funding for prevention and health education.