ORIGINAL RESEARCH

Assessing Local Public Health Governance in North Carolina Across Organizational and Governance Configurations

Karl Johnson, Juan Yanguela Eguizabal, Dorothy Cilenti, John Wiesman, Todd Jensen, Kristen Hassmiller Lich

BACKGROUND Every county in North Carolina must include a board of health (BOH) with specific prescribed duties and powers. It is unclear how BOHs in North Carolina are currently exercising their governance ability. In 2012, the North Carolina General Assembly provided counties with additional flexibility to select among different configurations for their local health department (LHD). The impact of this flexibility on the governance and service delivery of LHDs is yet to be explored.

METHODS We conducted semi-structured interviews with LHD directors and BOH members to assess the strengths and weaknesses of BOHs within different local public health configurations across North Carolina. We employed conventional content analysis to derive themes from the interview transcripts.

RESULTS BOHs were largely described as an underutilized institution, with few BOHs noted to be active beyond satisfying their required legal duties. Strong BOHs were noted to fulfill three identities on behalf of the LHD: an advocate, a bridge, and an advisor. The majority of interviewees desired to work in a standalone county health department (as opposed to a consolidated human services agency) with an appointed (versus elected) board of health. This configuration was preferred because, according to participants, it is more likely to enable a structural focus on public health initiatives.

LIMITATIONS Our sample frame did not control for the length of time an interviewee had been in the office nor the professional background of each BOH member.

CONCLUSIONS Wide variations exist in the exercise of BOHs across the state, partially due to how different LHD configurations structurally focus resources and attention on public health.

Under the North Carolina General Statutes, every county must have a local health department (LHD), a local health director (Director), and a governing board of health (BOH). The exact organizational and governance structure of these components can vary [1]. Traditionally, LHDs are single county health departments (CHDs), in which services are delivered to a single county, with governance provided by an appointed, county-specific BOH (Standalone BOH). Individual counties may also form consolidated human services agencies (CHSAs), in which multiple county human services functions or departments are consolidated into a single agency. CHSAs may be governed directly by a Board of County Commissioners (BOCC) or by an appointed consolidated human services (CHS) board, which must include members from a wide range of human services backgrounds. Counties may opt to form a multi-county district health department (DHD) that provides services for the residents of all counties in the district. DHDs are governed by a District BOH and are composed of members from each of the constitutive counties. Lastly, counties may opt to form a public health authority (PHA) that is entirely removed from county management (an additional configuration—a public hospital authority—is allowable by a 1997 law that only applies to Cabarrus County) [2]. Collectively, the organizational structure (CHD, CHSA, DHD, or PHA) and governance structure (Appointed Standalone BOH, BOCC as Standalone BOH, Appointed CHS Board, BOCC as CHS Board, or District BOH) constitute the LHD's configuration (Figure 1).

In 2012, the North Carolina General Assembly passed a law (Session Law 2012-126) that substantially modified the availability and structure of LHD configurations across the state [3]. Among other changes, it allowed BOCCs from any county to form CHSAs and/or to assume the legal powers and duties of a Standalone BOH or CHS board (thus forming a *Commissioner BOH*). Forming a Commissioner BOH must include the formation of an advisory committee reflecting the membership composition of a Standalone BOH, though the committee has no legal authority. Session Law 2012-126 also allowed CHSAs to remove LHD employees from what is now the State Human Resources Act (SHRA) and place them solely under county personnel policies [4].

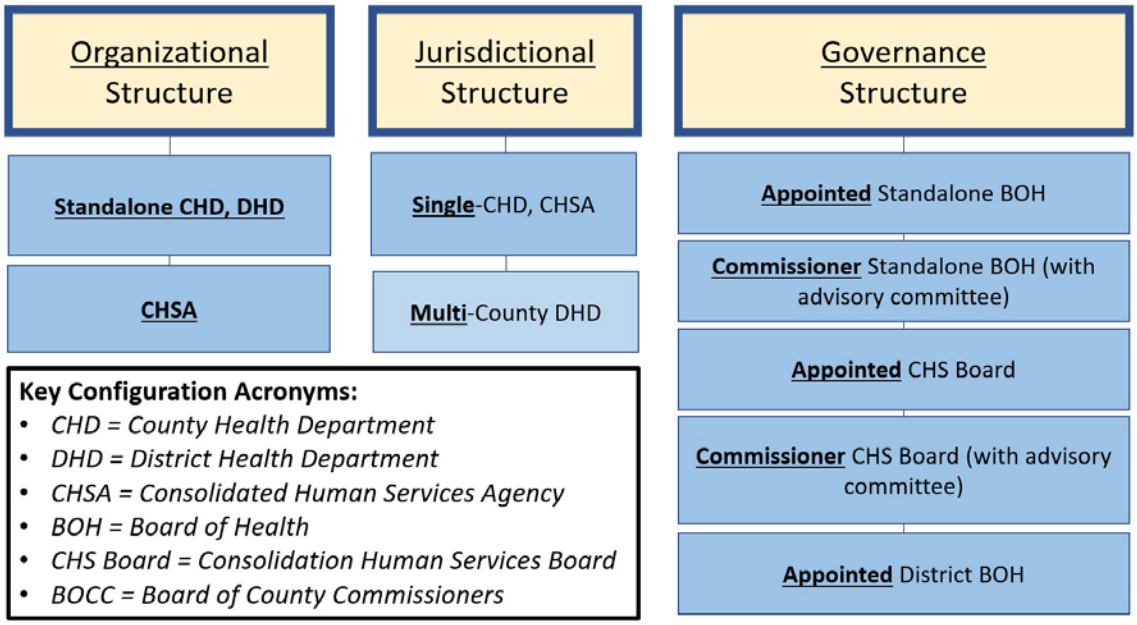
The configurations now widely available in North Carolina represent three distinct forms of restructuring

Electronically published September 9, 2024.

Address correspondence to Karl Johnson, Department of Public Health Leadership and Practice – University of North Carolina at Chapel Hill, 135 Dauer Dr, CB #7469, 4105 McGavran-Greenberg Hall, Chapel Hill, NC 27599-7469 (karl12@live.unc.edu)

NC Med J. 2024;85(5):XXX-XXX. 0029-2559/2024/85502

FIGURE 1.
Current Variations in LHD Configurations Across North Carolina



Note. This figure does not include different configurations available for Public Health Authorities (PHA), as no LHD is currently (as of May 2023) configured as a PHA in North Carolina.

when compared to a CHD with an appointed Standalone BOH: *organizational* restructuring (CHSAs), *jurisdictional* restructuring (DHDs), and *governance* restructuring (Commissioner BOH). In one way or another, each restructuring integrates decision-making processes for the LHD, ultimately shifting the power dynamics for the LHD-BOH relationship and, therefore, the prioritization of public health in the community. In the last 10 years, there has been a substantial proliferation in the different configurations for local governmental public health in North Carolina (Appendix 1.1), providing a natural opportunity to study how such variations impact LHD activity, including the LHD-BOH relationship (for an updated list of configurations, see the interactive maps from the Organization and Governance of NC Human Services Agencies at https://humanservices.sog.unc.edu/visualization-all/).

APPENDIX 1.1
Trends in Public Health Configurations Across North Carolina

This appendix is available in its entirety in the online edition of the *NCMJ*.

Methods

To collect data for this analysis, we conducted a set of semi-structured interviews with Directors and their BOH members across the state of North Carolina. Our sample of interviewees consisted of 19 Directors and 16 BOH members (Table 1). We developed an interview guide for all semi-structured interviews that included questions about the overall relationship between the LHD and the BOH, the impact of each of the three forms of restructuring on the work of the LHD, and the variation in local public health configurations across the state. We employed conventional content analysis to derive themes from interview transcripts (Appendix 1.2) [5].

APPENDIX 1.2
Extended Qualitative Methods

This appendix is available in its entirety in the online edition of the *NCMJ*.

Results

BOH Engagement and Opportunities for Improvement

The influence of BOHs varied considerably across different configurations, though examples of weak and strong BOHs were present in every model. Weak BOHs were marked by poor attendance at meetings, passive reception of LHD programming reports, and a conceptualization of the BOH's role as limited to voting on items identified by state statutes and reviewing the LHD's policies and budgets, as minimally required for accreditation. Alternatively, strong BOHs were often defined by their capacity to fulfill three core identities on behalf of the LHD: advisor, bridge, and advocate (Table 2). Most BOHs were much more likely to demonstrate advisor characteristics than those of an advocate or a bridge.

TABLE 1.
Interviewee Distribution Across North Carolina LHD Configuration

LHD Configuration	Number of LHDs in North Carolina (% of Total)	Interviewee Sample	
		Directors	BOH Board members
District Health Department	6 (7%)	3	1
County Health Department with Appointed BOH	48 (56%)	6	9
County Health Department with Commissioner BOH	4 (5%)	2	0
CHSA with Appointed CHS Board	15 (18%)	5	5
CHSA with Commissioner CHS Board	12 (14%)	3	1
Total		19	16

LHD = local health department; BOH = board of health; CHSA = Consolidated Human Services Agency; CHS Board = Consolidated Human Services Board; Director = local health department director.

The bare minimum of their requirements, they are doing that... I guess if you look at Board of Health responsibilities, their administrative stuff, they do that hands-down no problem. The advocacy piece...I think there is interest and a lack of understanding about how much and what they can do (Director, CHD, Appointed Board).

Interviewees identified opportunities for BOH improvement. Directors emphasized the need to better educate their BOH on LHD programs and the scope of their legal mandates. Likewise, Directors and BOH members desired additional direction on the responsibilities of BOH (e.g., how to best evaluate the LHD director). Many Directors also desired several changes to BOH composition, including the addition of categories of membership that are not currently mandated by law: non-voting young people, mental health professionals, emergency management leaders, nutritionists, non-allopathic health professionals, and more community participants. Likewise, Directors expressed a desire for training on how to identify potential BOH members with a genuine interest in public health and ensure authentic representation across all positions.

That's the health director's responsibility to make sure that they build a team that functions as more than just a sounding board, to build a team that has an interest in public health and wants to help you with your health department. It also depends on how much control that health director wants to have and how much they want to share (Director, CHD, Commissioner BOH).

My understanding of what the board's empowered to do, it's not clear. There's certain things we have to vote on, like the budget. Or we have to evaluate the health director...But if there's policies that we're supposed to help develop, I don't know what those are (BOH Member (Commissioner), CHD Appointed Board).

Trade-offs and Decision-making Between LHD Configurations

We asked interviewees about what they perceived as the strengths and weaknesses of each configuration, regardless of their current model. Table 3 outlines common interviewee responses to this question, along with examples of competing perspectives.

Several tradeoffs centered on how each model prioritized county resources and the attention given to public health. Commissioner BOHs enabled more efficient access to the funding and policymaking authority of the BOCC when the goals of the LHD and BOCC aligned but created a risk of LHD decision-making becoming influenced by local politics. DHD directors enjoyed how their model allowed for some independence from county management, though they noted the limited levels of county funding allocated for their work. Directors within CHSAs appreciated how at times their structure enabled better integration of resources between social services and public health, but many expressed frustrations over how CHS board meetings became dominated by the concerns of other human services (often social services). They also expressed concerns about how being overseen by a CHSA director or county manager (as opposed to the BOH) further removed them from a more direct relationship with the BOCC and the opportunities that such a direct relationship presents to voice their perspective to BOCC members.

I think that sometimes public health can get buried under the social services piece, right? You think about social services at the end of the day, that they're protecting vulnerable people, and they're having to do some really difficult things. And that can overshadow some of the preventative work and programming that public health needs to do and should do in the community (Director, CHD, Appointed Board).

Population size was also consistently discussed when considering alternative models, especially among county commissioners. For example, BOCCs from smaller counties found it more feasible for them to govern the LHD (2 of the 4 CHDs with a Commissioner BOH in North Carolina have fewer than 20,000 citizens). Alternatively, BOCCs from larger counties found it more important to have closer oversight of the LHD and DSS through forming a CHSA (8 of the 10 largest counties by population size in the state are CHSAs). Many interviewees recommended that smaller counties form DHDs.

Several strengths and weaknesses of each configuration were interrelated. Often, the identified strength or weak-

TABLE 2.
Characteristics of Strong Boards of Health

Characteristic Identity of BOH	Primary Audience	Core Activities	Illustrative Quote
Advocate	Board of County Commissioners (in Advisory Committees and appointed BOH models), others in local government	▪ Serving as an advocate on behalf of the LHD to the BOCC, especially in the context of budget proposals and policy recommendations. ▪ Speaking up for the LHD when conflicts occur between the LHD and BOCC (e.g., writing letters to BOCC to support LHD programming).	*"When you have those types of people at your side around you supporting you, speaking on your behalf, it is very helpful. It clears some hurdles with elected officials as well…So if you basically get into a situation that if these people [are] for it and they're speaking on your behalf, it puts you that much further down the road."* (Director, CHD, Appointed Board)
Bridge	Community members and partner organizations	▪ Participating in community-facing events put on by the LHD. ▪ Coordinating with other community organizations on strategic planning and referrals with the LHD. ▪ Providing additional "ears to the ground" to understand and relay community and other health professional needs to the LHD.	*"[The BOH] has been really good at taking my ideas and trying to coordinate some things with the hospital. So, we're working more as a team in the community than two separate entities."* (Director, CHD, Appointed Board)
Advisor	LHD staff and leadership	▪ Providing diverse professional perspectives on LHD programming and policy development. ▪ Broadening conversations beyond narrow LHD programmatic areas to larger health-related issues. ▪ Avoiding overstepping their governance authority and getting too involved in day-to-day operations. ▪ Being proactive in their recommendations and advice, as opposed to waiting for the Director to bring topics to them.	*"In terms of the way that the board is made up per general statutes…These are folks who [have] decades of experience in their craft, so they're able to provide that expertise."* (Director, CHD, Appointed Board)

ness reflected a different management preference among Directors and BOH members, marked by the degree of interaction between one or more governing entities. Whereas some Directors appreciated more direct access to the BOCC in a Commissioner BOH, others preferred how an appointed BOH protected them from local politics. Whereas some Directors appreciated having a multidisciplinary appointed BOH to report to and utilize as a sounding board and advocate, others were content or even appreciated the institution's absence, given what they perceived as the appointed BOH's limited utility and the time it took to manage BOH relationships. Likewise, whereas some county commissioners thought that appointed BOH oversight of the LHD provided a sufficient level of public accountability, others speculated that having more direct county control—whether through a CHSA and/or a Commissioner BOH—was necessary.

Conditions of Effective Implementation

Interviewees identified several conditions in which the implementation of each model would more likely be successful for advancing the mission of public health (Table 4). Most of these conditions emphasized improvements to one or more relationships between the various entities involved in governance, with a consistent emphasis on constant, transparent communication. Interviewees also emphasized training to learn about the constraints and resources available for each entity.

While examples of successful implementation were identified across each model, organizational and governance restructuring were consistently noted as challenging to implement. Directors indicated that managing LHD operations within CHSAs was unwieldy, that the additional human service divisions (especially social services) often made it challenging to sufficiently focus on public health concerns, and that meaningful integration of human services was challenging. Likewise, most interviewees perceived BOCC models to be too sensitive to political demands and BOCC members to be incapable, due to lack of time or expertise, of effectively governing the LHD. In general, both Commissioner BOH and CHSA models were characterized as structurally distracting from the singular focus on public health that CHDs and DHDs are more likely to provide, despite the benefits CHSAs and Commissioner BOH models may also provide. Several Directors went so far as to propose the elimination of CHSAs and Commissioner BOHs in North Carolina. Notably, no member of a CHD with an Appointed BOH or DHD expressed major complaints about working within their model.

> *When we had a Board of Health, we met with them monthly, and it was an hour to an hour and a half meeting…We got to sit and discuss lots of issues, and everybody got to verbalize what they wanted to verbalize. Now we go to the county commissioners' meetings quarterly and they do the county meeting and then they do the consolidated meeting. I feel like we're at the end, and whether it's been a good meeting or a bad meeting, we're at the end and it's just, we do our spiel* (Director, CHSA, Elected Board).

Perceived Origins of Session Law 2012-126

These critiques align with commentary on what interviewees generally perceived as the 2012 law's origin. Interviewees suggested that SL-2012-126 was adopted due to instances in which county management wished to terminate the LHD or DSS director but could not do so under the traditional CHD model (notably, hiring/terminating the Director was considered by BOH members to be one of their most important authorities). Likewise, interviewees suggested that many BOCCs formed CHSAs because

it allowed them to alter personnel policies for the LHD and DSS, given that CHSA formation allowed LHD and DSS staff to be placed under county personnel policies. In either case, the perceived intent of the BOCCs was not to improve service delivery through the meaningful integration of human services (via CHSAs) or to exercise improved governance over LHD programming (in Commissioner BOH models). To this end, some Directors remarked that if there were

TABLE 3.
Strengths, Challenges, and Competing Perspectives on Each Local Public Health Configuration

Form of Restructuring	Identified Strengths	Identified Challenges	Competing Perspectives
Jurisdictional (i.e., DHDs)	▪ Pooling of resources contributes to economic efficiencies. ▪ Restructuring between counties of different sizes can be used to "prop up" the resources of smaller, less resourced counties and therefore improve health equity. ▪ DHD directors appreciate the additional autonomy ("pseudo-independence") from county governance, especially regarding the access of additional funding streams.	▪ DHD members noted the complexity of working to coordinate with multiple sets of government agency partners. ▪ The cost of initially forming a DHD was seen as prohibitive to some. ▪ Fairly balancing needs/resources and communications across multiple counties, especially multiple BOCCs, can be difficult.	▪ Those outside DHD generally believe DHDs get more funding overall from BOCCs; those in DHDs emphasize the limited funding they receive from their BOCCs. ▪ Those outside DHDs believe managing across multiple counties is overwhelming; those in DHDs recognize this challenge, but think it is doable and worthwhile (the current DHDs have been in existence for several years, which may explain their comfortability with this management). ▪ Many Directors believe more small counties should be in DHDs than current exist; for small counties that are not in DHDs, most think neighboring counties are too different from them or their BOCCs do not wish to give up local control (feelings of local autonomy noted as especially strong in small, rural counties); BOCCs from small counties that could form DHDs generally think their regional work (without becoming a district) is sufficient.
Organizational (i.e., CHSAs)	▪ From citizen/consumer perspective, having a "one-stop-shop" is easier to navigate. ▪ Integration between social services and public health (PH) considered an ideal configuration to address social determinants of health. ▪ Appointed CHS boards have a more diverse range of professional perspectives (compared to a BOH), which can facilitate more holistic or comprehensive programming/policies. ▪ BOCCs believe CHSAs can save county managers time, as they now just have a CHSA director to interface with, not both DSS director *and* LHD Director.	▪ CHSAs do not automatically lead to integrated services; strong leadership must be involved to effectively integrate staff and, more importantly, processes (e.g., shared screening tools, warm referrals). ▪ Health and public health-related concerns often don't get the same level of attention in CHS board meetings; conversations can be crowded out by DSS-related concerns. ▪ Possibility for confusion over responsibilities between DSS and PH work. ▪ The CHSA director position demands knowledge of all the rules and programs associated with each agency, which can be hard to find (especially in smaller counties). ▪ CHSAs create additional layers of governance above Director, making them further removed from county government.	▪ Some believe CHSAs force integration between DSS and LHDs where it may otherwise not exist; others believe that integration can occur if the two agencies are merely collocated. ▪ CHSAs remove LHDs from being under the SHRA (as a default). Removal from the SHRA provides more flexibility in changing job descriptions/salaries, but employees no longer have the same state-level appeal protections if they are fired. ▪ BOCCs consistently believe that CHSAs save money, primarily through merging personnel. No Director within a CHSA model agrees, suggesting it is more expensive due to the increased cost of a CHSA director. ▪ Some believe in strong overlap between DSS and LHD culture and programming, emphasizing they are both human services and serve, at times, a very similar population. Others emphasize that DSS is more focused on low-income persons and LHD is more focused on the general population, or that both are highly regulated by state funding/mandates which prevents deep integration.
Governance (i.e., Commissioner BOH)	▪ Many processes can happen more efficiently (i.e., don't have to get approval of BOH *and* BOCC). ▪ If BOCC is "pro-public health," it may provide more opportunity for funding. ▪ Simpler and more "holistic" governance with one BOCC overseeing everything, PH included, in the county. ▪ BOCC gets information from LHD more directly (does not have to pass through BOH), leading to opportunities for better relationship between LHD and BOCC and for BOCC to become more educated on PH programming. ▪ Forces BOCC to become more accountable for LHD performance.	▪ County commissioners may overly focus on funding constraints when considering new PH programs/policies. ▪ BOCCs can experience high turnover, which demands a significant amount of time spent educating new county commissioners on PH. ▪ BOCCs don't have the necessary medical/health background to make PH-related decisions for the LHD. ▪ Harder to gain consensus on BOCC, given that they don't all come from health backgrounds. ▪ Often the advisory committee (AC) is responsible for most of the former BOH responsibilities, with commissioners rarely attending AC meetings. ▪ Few ideas leave the AC and make it to the BOCC. ▪ Most ACs experience weaker member attendance and participation compared to prior BOH, given limited power influence over the LHD and BOCC. ▪ A BOCC does not have the time capacity to effectively govern the LHD.	▪ Whereas most Directors believed that Commissioner BOH allow for BOCCs to make PH decisions for political reasons (appointed BOH is buffered more from politics), Directors within Commissioner BOH expressed this is not often the case until something explicitly political occurs. ▪ Some BOCCs conceptualized it as a model for them become more responsive to constituent needs regarding health, given that people look to them as publicly responsible for the LHD; other BOCCs considered their oversight of an appointed BOH to be a sufficient level of accountability. ▪ Most commissioners believed they don't have the capacity to attend to LHD with all their other board responsibilities and that very little time is given to LHD priorities during BOCC meetings; a handful of commissioners from smaller counties imagined serving as the BOH to be more manageable.

TABLE 4.
Conditions of Effective Implementation Across Three Models of Restructuring

Form of Restructuring	Critical Conditions of Effective Implementation	Illustrative Quote
Jurisdictional restructuring (District health departments)	1. Open, constant communication between the LHD and each of the commissioner representatives from each county. 2. Sense of shared responsibility (even if not perfectly shared financial contribution) among participating counties. 3. Respect for semi-independence of the DHD while maintaining a strong connection between DHD and county government among each of the participating counties. 4. Capacity and willingness for DHD to secure funding outside local appropriations, given limited county funding.	*"And so as long as you can be open, you can have that open communication, establish those ground rules, then it really is a great opportunity. It's a great way to stretch that dollar and really use those resources wisely."* (Director, DHD)
Governance restructuring (Commissioner BOH)	1. Attention and respect given to the advisory committee, including consistent attendance from a county commissioner at advisory committee meetings. 2. Ensuring that results of advisory committee discussions reach BOCC meetings. 3. Ensuring clearly dedicated and sufficient time given to addressing BOH-related issues, whether during BOCC meetings or in separate BOH-specific sessions.	*"I would say that having the elected board of commissioners be the governing body though is challenging because you don't have their ear as much as you would for an advisory board. They're much more challenging to get connected to. They have a lot of things happening. They're trying to manage the entire organization and from their lens, the entire county essentially."* (Director, CHD, Elected Board)
Organizational restructuring (CHSAs)	1. Ensure CHSA director has a background in PH, a willingness to learn about PH programs/policies, or appropriate deference to Director on public health issues. 2. If removed from SHRA, thoroughly explain to CHSA staff how the change to county personnel policies will impact their employment. 3. Ensure enough space is provided for PH agenda topics during CHSA board meetings.	*"That's been the biggest struggle with the health and human service agencies across the state, is just figuring out where that line draws. Traditionally the public health director has certain authorities that I think are important for the public health director to have. In some communities it depends on the skillset of the consolidated human service agency director. For example, our consolidated human service agency director will not say [they're] a public health expert. When it comes to issues of public health, [they] defer to me and don't try to be the public health director. Some communities that's not always the case."* (Director, CHSA, Elected Board)
All forms of restructuring	1. Constant, comprehensive education of BOCC members on the mission and scope of PH. 2. Constant, comprehensive education of BOH members on their roles and responsibilities. 3. Maintaining good relationships with county manager across all configurations (even if LHD Directors do not directly report to them), as the county manager likely has the attention of the BOCC more than BOH members or LHD leadership.	*"It actually comes a lot from the county manager first. He does a lot of work around communication with our board and making sure that they're knowledgeable about everything that's happening across the organization. I know if I get in front of him and I'm able to present kind of what it is that they need to know that's going to get to them, and then inadvertently I get that support back from them."* (Director, CHD, Elected Board) *"We need more engagement with county commissioners to understand local public health and their role in supporting it."* (Director, DHD)

other mechanisms for BOCCs to address personnel issues or if these issues never existed, configuration restructuring would not have occurred. Less frequently, interviewees perceived that BOCCs pursued organizational restructuring to decrease the size of government or to save the county money, although no Director confirmed that CHSAs have in fact saved money. One interviewee noted that the LHD is one of the highest-revenue-generating departments of local government, which may have prompted interest among the BOCC for closer management of its operations.

> *In a lot of ways [this] is why some counties have elected to shift the Board of Health to the Board of Commissioners because they wanted to retain that ability to make the budgetary decisions as well as make the personnel related to decisions. Our board of commissioners oftentimes is not interested in making any of the other…They really just don't want to be bothered with it unless it has to be a rule making policy decision…They'd rather the advisory board had the authority…to do all the obligations related to accreditation. However, the way it's outlined currently, that's not a possibility. It's either all or nothing* (Director, CHD, Elected Board).

Discussion

The BOH-LHD relationship can be a strong institution for advancing local public health, but it demands structural conditions as well as personal buy-in from both BOH members and LHD leadership. These conditions were not often present within our sample. While a handful of Directors considered BOHs invaluable to the work of the LHD, most argued that their BOH served, at best, as a passive sounding board. Given the instrumental role BOHs may have in local public health and their duty to uphold various statutory responsibilities, it is essential to educate and empower all those involved in local public health governance on how to better their ability to uphold those responsibilities.

Within North Carolina, training for new BOH members as

well as ongoing training (provided at least once during an accreditation cycle) is required to satisfy state LHD accreditation requirements [6]. However, the majority of this training focuses on educating new or current BOH members on the legal powers and responsibilities of BOH (e.g., how to adopt local public health rules). Based on the results of this study, additional training should be provided (to both BOH members and LHD leaders) on the skills and best practices associated with BOHs going beyond the "bare minimum" that is formally required by law or for accreditation so that they can become a stronger advocate, advisor, and bridge for the LHD. Given the dynamic pace at which public health challenges evolve, training should be given more frequently than accreditation cycles.

In advance of the changing legislation in 2012, scholars at the University of North Carolina School of Government interviewed local and state public health leaders on the perceived strengths and challenges of each configuration [7]. However, since the study's publication in 2013 (the "2013 Report") there has been a substantial proliferation in the number of CHSAs and Commissioner BOHs [8]. Given the overlapping research questions, we encourage our results to be reviewed in concert with and as a continuation of results from the 2013 Report.

The authors of the 2013 Report noted a fear among their interviewees that politics would control the LHD agenda within Commissioner BOH models and that the BOCC would not be capable of fulfilling the BOH's responsibilities. The results of our study largely confirm both fears. Commissioner BOH models were described as overly focused on financial stewardship, liable to make decisions based on political pressures, and likely to largely relegate the majority of their BOH responsibilities to their advisory committee (a weakened institution compared to the BOH). Many directors noted that the influence of political pressures on public health decisions was especially challenging during the COVID-19 pandemic, a moment of crisis between public health and politics that could not have fully been anticipated when the 2013 report was conducted. However, a small handful of Directors noted that Commissioner BOH models are not entirely negative for the LHD, especially during seasons in which the LHD's programming does not seriously conflict with the political interests of the BOCC. During such seasons of "peacetime" (Director, CHSA, Appointed Board), a Commissioner BOH can enable more efficient decisions and greater access to resources, with its advisory committee exercising the best advisor qualities of an appointed BOH (for an extended discussion on each form of restructuring, see Appendix 1.3).

Limitations

There are several limitations to this analysis, most of which concern our sampling frame. We did not interview county managers, who play a critical role in local public health governance, though the role of county managers was often discussed among interviewees. County managers are especially influential within CHSAs, given their role in hiring and terminating the CHSA Director, and within LHDs with a Commissioner BOH, given the close relationship between county managers and BOCCs. Likewise, while we sought representation across each configuration, we were not able to contact and interview county commissioners from CHDs with a Commissioner BOH (in one instance the LHD director was not comfortable with them being interviewed, and in all other instances they were not reachable after several contact attempts). However, we were able to interview county commissioners from CHSAs governed by a Commissioner BOH, as well as county commissioners from other models. We also asked each county commissioner we interviewed about their thoughts on forming a Commissioner BOH.

APPENDIX 1.3
Impact of Restructuring

This appendix is available in its entirety in the online edition of the *NCMJ*.

Conclusions

We found that within North Carolina, a BOH is largely an underappreciated and underutilized institution across the state, even though it has the capacity to provide "invaluable support" (Director, DHD, Appointed Board) to the LHD when it fulfills core identities that go beyond what is minimally required by law. We also found that variations in local restructuring—organizational, jurisdictional, governance—strongly shape the LHD-BOH relationship, either by further empowering their activity or distracting them with concerns of other agencies or local political dynamics. When considering changes to local public health organization and governance, local practitioners and policymakers should consider how such changes will shift this relationship before making what is often a long-term solution for public health service delivery in the community. Given the most updated results from the recent proliferation of various organization and governance models across North Carolina, current BOCCs, BOHs, and Directors should reconsider whether governance shifts that may have happened several years ago reflect what is best for community health in their locality at the present time. NCMJ

Karl Johnson, PhD Assistant Professor, Department of Public Health Leadership and Practice, Gillings School of Global Public Health, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.
Juan Yanguela Eguizabal, MSc PhD Candidate, Department of Health Policy and Management, Gillings School of Global Public Health, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.
Dorothy Cilenti, MSW, DrPH Clinical Professor, Department of Maternal and Child Health, Gillings School of Global Public Health, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.
John Wiesman, DrPH, MPH Professor of the Practice, Department of Health Policy and Management, Gillings School of Global Public Health, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.

Todd Jensen, MSW, PhD Research Assistant Professor, UNC School of Social Work, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.
Kristen Hassmiller Lich, PhD Associate Professor, Department of Health Policy and Management, Gillings School of Global Public Health, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.

Acknowledgments

We wish to acknowledge Kristi Nickodem (Assistant Professor of Public Law and Government, University of North Carolina at Chapel Hill) for her assistance in helping us understand the options and requirements for public health organization and governance models under North Carolina law, as well as her assistance in helping us contextualize interviewee commentary.

Declaration of interests. All authors report no conflict of interest.

References

1. More J. Chapter 38: Public Health. In: *County and Municipal Government in North Carolina.* 2nd ed. School of Government. The University of North Carolina at Chapel Hill; 2014.
2. Moore J, Nickodem K. How does a public health authority compare to the public hospital authority that operates in Cabarrus County? School of Government. The University of North Carolina at Chapel Hill. www.sog.unc.edu/resources/faqs/how-does-public-health-authority-compare-public-hospital-authority-operates-cabarrus-county
3. Nickodem K. North Carolina Human Services Agencies: Options For Organization And Governance. School of Government. The University of North Carolina at Chapel Hill. 2022. www.sog.unc.edu/sites/www.sog.unc.edu/files/Options for Organization and Governance of NC Human Services Agencies_0.pdf
4. Wall A. An update on recent changes for local human services agencies. Coates' Canons NC Local Government Law. 2013. https://canons.sog.unc.edu/2013/04/an-update-on-recent-changes-for-local-human-services-agencies/
5. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res.* 2005;15(9):1277–1288. doi:10.1177/1049732305276687
6. North Carolina Local Health Department Accreditation Board. Health department self-assessment instrument (HDSAI) interpretation document. 2023. https://nclhdaccreditation.unc.edu/wp-content/uploads/sites/733/2022/12/HDSAI-Interpretation-Document_2023.pdf
7. Wall AN. Comparing North Carolina's local public health agencies: The legal landscape, the perspectives, and the numbers. School of Government. The University of North Carolina at Chapel Hill. 2013. www.sog.unc.edu/resource-series/comparing-north-carolina%E2%80%99s-local-public-health-agencies-legal-landscape-perspectives-and-numbers
8. Nickodem K. North Carolina's changing landscape of public health and social services governance and agency structures: Where are we now? Coates' Canons NC Local Government Law. 2022. https://canons.sog.unc.edu/2022/03/north-carolinas-changing-landscape-of-public-health-and-social-services-governance-and-agency-structures-where-are-we-now/

APPENDIX 1.1
Trends in Public Health Configurations Across North Carolina

LHD Configuration	July 1, 2012 (While the 2013 report was conducted)	April 1, 2013 (Immediately after the 2013 report was conducted)	May 1, 2022 (When this study began)
CHD, Commissioner BOH	0	0	4
CHD, Appointed BOH	75	68	48
CHSA, Commissioner BOH	1	5	12
CHSA, Appointed Board	1	4	15
District Health Department, District BOH	6	6	6
Public Hospital Authority, Public Health Authority Board	1	1	1
Single County Public Health Authority, Single-County Public Health Authority Board	1	1	0
Multi-County Public Health Authority, Multi-County Public Health Authority Board	0	0	0

APPENDIX 1.2
Extended Qualitative Methods

Using an inductive, iterative approach, we first outlined a preliminary codebook derived from the interview guide. Additional codes emerged as we analyzed a random sample (n = 4) of transcripts; new codes were added as data we encountered didn't fit an existing code until no further codes were needed. We used ATLAS.ti qualitative analysis software (Version 23.0.6) to apply codes to each of the transcripts. To ensure reliability and comprehensiveness of coding, application of codes was done by two independent coders. Once independent coding was completed, interrater reliability, assessed by the percent agreement between codes, was measured to assess coding reliability. We assessed the percent agreement using MAXQDA 2022 software, (VERVI Software, 2021). Percent agreements above 80% reflect strong agreement. After coding all transcripts, the percent agreement between the two coders was evaluated to be 72%. Coders met to resolve coding disagreements until percent agreement for each individual code was above 80%, resulting in an overall percent agreement of 82%. Transcript segments associated with each code were separately analyzed to identify patterns of interviewee commentary within that code.

Please contact the lead author if interested in accessing our interview guide.

APPENDIX 1.3
Impact of Restructuring

Taken together, our findings on the effects of CHSAs and Commissioner BOH suggest that with the loss of an appointed BOH composed of medical professionals who are strictly concerned with overseeing and guiding the LHD, the LHD becomes structurally less concerned with and less empowered to respond to public health needs in the community. While this shift may come at the benefit of increased accountability to elected officials or marginally improved integration of human services, it rarely maintains or improves the performance of public health service delivery. Moreover, one of the main perceived drivers of the 2012 Law—the desire to remove LHD employees from the SHRA—has largely been confirmed: nearly every county that has formed a CHSA in the last decade has removed the CHSA employees from the coverage of the SHRA. However, given the challenges associated with CHSAs, these data point to an alternative policy solution. Instead of only allowing counties with CHSAs to remove social services and public health employees from the coverage of the SHRA, the North Carolina General Assembly could allow all DSS and LHD employees to be exempt from the SHRA so long as counties comply with the federal merit personnel standards with respect to these employees (as is currently required for CHSAs). This change would help to ensure that counties create CHSAs for the purpose of integrating human services or improving public health service delivery, as opposed to the mostly unrelated concern of changing personnel policies and procedures.

The challenges identified within forms of governance restructuring also reflect the difficulties that emerge when Directors must work with local elected officials to deliver critical public health goods and services. Scholars of public administration have long studied whether and how public managers balance political involvement and administrative neutrality. Classically referred to as the "politics-administration dichotomy," this challenge is defined by striking a balance between the managerial competence of appointed bureaucrats and their accountability to elected representatives. In the case of LHDs, this manifests in tensions between the scientifically minded direction of LHD leadership with the political agenda of the BOCC (especially in Commissioner BOH models). As outlined in recent public administration scholarship, current emphasis is placed on a complementary relationship between the two roles: elected officials must respect the competence and commitment of appointed administrators (i.e., LHD leadership) and managers must be accountable to the political goals of their elected officials, thereby avoiding political dominance or bureaucratic autonomy. To maintain complementarity, an emphasis is placed on ongoing interaction, reciprocal influence, and mutual deference, including opportunities for administrators to shape policy and for elected officials to oversee implementation.

Lastly, findings from our interviews confirm the economic interest in jurisdictional restructuring, especially among smaller, rural LHDs. Jurisdictional restructuring due to differences in LHD resource capacity was one of the most consistent arguments made for having flexibility to choose different configurations at the local level. However, along with cost savings, Director interviewees emphasized potential benefits of the semi-independence of DHDs from county-level governance. While many Directors who were not in DHDs thought it would be challenging to manage across county lines, this was not a major concern for Directors who had been operating in a DHD. Our results further confirm the political and cultural challenges to jurisdictional restructuring, as many BOCC members we interviewed seemed unwilling to give up local control and suggested that the benefits of jurisdictional restructuring could be achieved without fully becoming a DHD. Notably, while the number of CHSAs and Commissioner BOHs have proliferated in the last 10 years in North Carolina, no new DHDs have formed, reflecting the strength of this resistance to giving up local control. And yet, the commissioner representatives from district BOH we interviewed did not express a concern about having lost oversight or autonomy. The policy implication of these results aligns with those that have been offered in prior studies: state and federal governments should consider further encouraging (e.g., through subsidizing upfront expenses) the formation of DHDs among rural, sparsely populated counties where there is strong cultural and geographic fit, while using anecdotal evidence from established DHDs on the reality of what DHD formation implies for BOCC oversight and Director managerial responsibilities.