**Impact Analysis for Repeal of 10A NCAC 48A and 48B and Adoption of 48C and 48D**

| | |
|---|---|
| Agency | NC Commission for Public Health<br>NC Department of Health and Human Services, Division of Public Health |
| Rule Citation(s): | Repeal:<br>10A NCAC 48A and 48B<br><br>Adopt:<br>10A NCAC 48C .0101 – Purpose<br>10A NCAC 48C .0102 – Definitions<br>10A NCAC 48C .0201 – Self-Assessment<br>10A NCAC 48C .0202 – Site Visit<br>10A NCAC 48C .0203 – Board Action<br>10A NCAC 48C .0204 – Informal Review Procedures<br>10A NCAC 48C .0205 – Applying for Accreditation<br>10A NCAC 48D .0101 – Purpose<br>10A NCAC 48D .0102 – Definitions<br>10A NCAC 48D .0103 – Accreditation Requirements<br>10A NCAC 48D .0201 – Standard A: Assessment and Surveillance<br>10A NCAC 48D .0202 – Standard B: Community Partnership Development<br>10A NCAC 48D .0203 – Standard C: Communications<br>10A NCAC 48D .0204 – Standard D: Emergency Preparedness & Response<br>10A NCAC 48D .0205 – Standard E: Structural and Social Determinations of Health<br>10A NCAC 48D .0206 – Standard F: Organizational Workforce Development<br>10A NCAC 48D .0207 – Standard G: Organizational Leadership, Governance, and Legal Services<br>10A NCAC 48D .0208 – Standard H: Organizational Facilities<br>10A NCAC 48D .0209 – Standard I: Organizational Finance and Information Technology<br>10A NCAC 48D .0210 – Standard J: Accountability and Performance Management<br>10A NCAC 48D .0211 – Standard K: Policy Development and Support |
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| Rulemaking Authority: | N.C.G.S. 130A-34.1 |
| Impact Summary: | State Government: Yes<br>Local Government: Yes<br>Private Sector: No<br>Substantial Impact: No |

## Executive Summary

The NC Commission for Public Health is proposing to repeal and replace its local health department accreditation program rules following a comprehensive multi-year review. Established under the authority of G.S. 130A-34.1, North Carolina's local health department accreditation rules aim to ensure consistent quality, capacity, and accountability of local health departments (LHDs) across the state. The role of LHDs is to ensure access to essential public health services and promote population health across the state. The services LHDs provide include communicable disease control, chronic disease and injury prevention, environmental public health, maternal, child, and family health, and access to and linkage with clinical care.

The proposed rules incorporate elements from the updated Foundational Public Health Services Framework, eliminate duplicative requirements, shift the focus from capacity-building to performance improvement, and retain the minimum accreditation standards mandated by G.S. 130A-34.1(e). As a result, there is a proposed reduction in the number of accreditation activities from 147 to 45. These changes are expected to result in the following costs and benefits:

State Government

- One-time opportunity costs of approximately $70,000 to NCIPH staff for updating accreditation materials, preparing training materials, and conducting trainings.
- One-time costs of $3,500 to cover travel costs for LHD site visitors to attend in person training on updated rules. This will be paid from existing accreditation funds received from fees paid by LHDs.
- Potential ongoing cost savings of up to approximately $7,000 per year due to a reduction in required site visitors from four to three.
- Improved rule clarity and streamlined requirements that are likely to reduce the time DPH and NCIPH staff spend on technical assistance to LHDs, resulting in ongoing opportunity cost savings.

Local Government

- It is expected that the Agency Accreditation Coordinator (AAC) within each LHD will need to be trained on the new rule requirements and will also need to make changes to the way accreditation materials are collected and organized. This one-time opportunity cost is estimated to be between $61,000 and $91,000 across all 86 LHDs. This estimate is based on reasonable assumptions, but the actual total costs could be higher or lower due to factors such as differences in pay rates among AACs and the number of staff assigned to support accreditation at a given LHD. Nevertheless, this estimate gives a general idea of the expected magnitude of the potential impact.
- This opportunity cost is expected to be more than offset by future long-term time savings for AACs in gathering and organizing documentation due to reduced and streamlined accreditation activities. In total, the potential time saved is estimated at 150 hours in non-accreditation years and 240 hours in accreditation years per LHD. Average annual opportunity cost savings across all 86 LHDs are estimated to be between $515,000 and $546,000, or approximately $6,000 per LHD per year. This estimated range is meant to provide a general idea of the magnitude of the expected potential impact. It is important to note that the job classifications and salaries of AACs as well as the extent of administrative support for accreditation vary widely across LHDs. As such, the actual savings in a given year or for a given LHD could be higher or lower. For an individual LHD, the amount of opportunity costs and savings will be largely dependent on the salary of the AAC and any administrative staff supporting accreditation. Savings will be higher in accreditation years versus non-accreditation years. Decreasing demands on AACs may also lead to better LHD retention of AACs, which tend to have high turnover.

Public health

Ongoing benefits associated with accreditation of LHDs include:

- Accreditation has led to improvements in organization, policy updates, quality improvement activities, and strengthened local partnerships among health departments. It also provides a framework for measuring performance and promoting a culture of excellence in public health services.
- Streamlining and updating accreditation activities as proposed will ensure that the required activities better reflect today's demands on public health, including a thorough response to outbreaks and disasters, improved use of data to determine the use of resources and targeting services, and comprehensive policies and procedures that are unified and practical.
- Using the new standards could result in additional benefits to the LHD and the public in the form of quicker response to and mitigation of outbreaks, programs that better address the needs of people in the jurisdiction, improved strategic priorities that are monitored and revised based on data, and resource and facility use that reflects and supports the mission of the LHD. These benefits will be spread across the state and will be ongoing.

## Background

The NC Local Health Department Accreditation (NCLHDA) Program (hereinafter, the "Program") was initially developed in 2002 by local health directors from across North Carolina with support from the Division of Public Health (DPH) within the North Carolina Department of Health and Human Services (NCDHHS). In 2006, local health department (LHD) accreditation became a legislatively mandated process as outlined in G.S. 130A-34.1, making North Carolina the first state in the nation to mandate accreditation for LHDs. Since the Program started, it has been a national model for other local, state, and tribal health department accreditation programs.

Per G.S. 130A-34.1, NC LHDs must obtain and maintain accreditation through the NCLHDA Board every four years. Statute defines the NCLDHA Board (Board) and establishes the Board within the North Carolina Institute for Public Health (NCIPH), which is situated at the Gillings School of Global Public Health at UNC Chapel Hill. The Commission for Public Health (CPH) has the authority to adopt rules governing accreditation after reviewing and consulting with the Board. The current rules, set out in 10A NCAC 48A and 48B, first went into effect in January 2006. These rules define accreditation processes, the standards, benchmarks, activities that make up accreditation, and the scoring requirements that LHDs must satisfy. If accreditation is not met, the LHD may be assigned conditional accreditation for a period of two years, during which they may work to become fully accredited.

NCIPH administers the Program through accreditation staff and independent contractors, who serve as peer site visitors. Accreditation staff work closely with the Board and LHDs to administer site visits, update Program procedures, develop and deliver training, conduct Program evaluations and annual surveys, and provide resources to LHDs. All LHDs designate an Agency Accreditation Coordinator (AAC) to coordinate an agency's accreditation evidence and serve as a point person between the Program and LHDs.

While the accreditation requirement is in statute, there is currently no funding in the state budget to support implementation. While initially there were legislated funds, the funding was eliminated in SFY 2010. Fees paid by LHDs were implemented in 2011. Currently LHDs pay a minimal annual fee that primarily supports

site visits and a portion of staff time. Annual fees are determined collaboratively by NCIPH and the NC Association of Local Health Directors (NCALHD). The fees have remained at current levels since 2019.

In 2019, the Board began a multi-year process to review and update the Program, including the requirements in administrative code. A Standards Workgroup, made up of Board members, local health directors, DPH staff, site visitors, and AACs met to discuss and provide feedback on requirements. Additional feedback was solicited through open comment processes and input from additional groups such as the AAC Advisory Committee and the NCALHD. Following this review and feedback process, the Board recommended the proposed rules to the Commission for Public Health.

The repeal and replacement of the existing accreditation rules provides an important opportunity to update the measures used to assess an LHD's capacity and capability to provide public health services and more closely align those measures with current best practices. When originally developed, many of the tasks required to demonstrate achievement of a standard (i.e., "activities") were structured to build capacity to perform public health services and programs. Now that all LHDs have been accredited and reaccredited, the initial capacity has been well established and reviewed, providing an opportunity to update accreditation activities to focus on performance improvement while still fulfilling statutory requirements. There has been a longstanding need for comprehensive and comparable data among LHDs in NC, and the Program can play a role in establishing consistent expectations across the state. This is especially true with a growing focus on using data and metrics to guide decision making and implement programs and interventions.

A crosswalk between the activities required under the current rules and the activities required under the proposed rules is included in **Appendix A**. This crosswalk was created to show how requirements transformed and also demonstrate how the new proposed rules will continue to fulfill all the requirements for standards set out in G.S. 130A-34.1(e).

As part of the review process, there is a proposed reduction in the number of activities from 147 to 45. The reduction in activities acknowledges the shift in the focus of accreditation from building capacity to improving performance and eliminates duplicative requirements. In addition, the statutory requirements and current administrative rules are based on the Ten Essential Public Health Services Framework, which was created in the 1990s. Public health frameworks have been revised and updated since that time. The proposed rules include the elements of the Ten Essential Public Health Services Framework, but also include elements from new frameworks, including the Foundational Public Health Services (FPHS) Framework.[1] FPHS is a framework for public health practice and delivery of services. The structure of the rules follows the FPHS framework but contain within them all elements required by G.S. 130A-34.1(e).

## Description of Proposed Rules

The text of the proposed rules is included in **Appendix B**.

Accreditation Administration (10A NCAC 48A/48C)

> In the current rules, Subchapter 48A contains the requirements for administering the Program. In the proposed rules, this has been replaced by Subchapter 48C, which has a similar structure and contains many of the same requirements.

[1] Public Health Accreditation Board. "The Foundational Public Health Services". https://phaboard.org/center-for-innovation/public-health-frameworks/the-foundational-public-health-services/. Accessed 10 December 2024.

The definition rule (10A NCAC 48C .0102; previously 10A NCAC 48A .0102) has been expanded to further clarify the terms used. The self-assessment section (10A NCAC 48C .0201; previously 10A NCAC 48A .0201) has been updated to more clearly set out the components of the self-assessment and how it is submitted. The site visit rule (10A NCAC 48C .0202; previously 10A NCAC 48A .0202) has been updated to reduce the number of site visitors required on a site visit team from 4 to 3 and make clarifying changes to processes. The Board action rule (10A NCAC 48C .0203; previously 10A NCAC 48A .0203) has been expanded to more clearly set out the actions the Board may take, to make accreditation effective the first day of the month and expire the last day of the month, and to allow for flexibility in the event of an emergency. In the past, when there was an emergency, it has been difficult for LHDs to prepare for site visits, for site visitors to conduct site visits, and/or for the Board to meet and adjudicate accreditation. A recent example of this occurred during the COVID-19 pandemic, during which gubernatorial action was needed to extend accreditation statuses. This proposed change would allow the Board to be responsive to emergencies, such as hurricanes and other natural disasters impacting NC counties. The proposed rules would allow for an extension of accreditation up to 90 days after the end of the emergency declaration. The LHD would then be adjudicated and an accreditation status awarded. The informal review procedures rule (10A NCAC 48C .0204; previously 10A NCAC 48A .0204) has been clarified to set out what information an LHD should provide and how it should be provided for review. Finally, the re-accreditation rule has been renamed "Applying for accreditation" (10A NCAC 48C .0205; previously 10A NCAC 48A .0205) and has been updated to describe all the situations in which an LHD may be applying for accreditation, including re-accreditation, accreditation following creation of or withdrawal from a district health department, and applying for accreditation if previously assigned a conditional or unaccredited status.

Accreditation Standards (10A NCAC 48B/48D)

The purpose and definition rules (10A NCAC 48B .0101/.0102) have now been consolidated into 48C. The accreditation requirements rule (10A NCAC 48D .0101; previously 10A NCAC 48B .0103) contains an updated scoring algorithm, which includes partial credit for a partially met activity. Currently all activities are scored on a met/unmet basis, so this new method allows for additional flexibility. The change will allow site visitors to recognize those elements of an activity that are met, even if not all elements of a particular activity are met. The scoring will be done through a point system with 90 possible points. A LHD must score an 81 or higher with at least 4 points falling in each standard to be accredited. The intent of this change is to be more accurate in the scoring of requirements and make space for the Program/site visitors to provide feedback to the LHD for improvement. The Program does not expect this to change whether a health department would be accredited.

Based on the work of the Standards Workgroup and broad input, including from the Board, the proposed rules reduce the number of activities from 147 to 45. A few examples of proposed deletion/consolidation of activities include the following:

- Under the current rules there are 27 activities for the Board of Health. Many of these overlap or are duplicative of activities that apply to the LHD overall. Under the proposed rules, there will be one specific activity for governance.
- Under the current rules, there are three activities regarding laboratory services which have now been consolidated into one activity.
- Under the current rules there are 10 activities related to Emergency Preparedness & Response across the rules. This has now been consolidated to one standard with 5 activities, which remove duplicative requirements.

As noted above, the structure of the rules follows the FPHS framework, but contains within them all elements required by G.S. 130A-34.1(e). The framework has been divided into 11 standards that represent the crosscutting skills and capacities needed to support basic public health protections and other programs and activities that are key to ensuring the community's health. The expectation is that this represents a basic level of capacity at every LHD in North Carolina.

The 11 Standards are:

**10A NCAC 48D .0201 Standard A: Assessment and Surveillance**
This standard measures the LHDs capacity to track the health of the community through data, health assessment, case findings, and laboratory tests, with particular attention to those most at risk. There are five activities within this standard.

**10A NCAC 48D .0202 Standard B: Community Partnership Development**
This standard measures the LHDs capacity to harness and align community resources to advance the health of all community members. It seeks to build relationships with partners from various sectors in the community and seeks input into department programs and services. There are three activities within this standard.

**10A NCAC 48D .0203 Standard C: Communications**
This standard measures the LHDs capacity to reach the public effectively with timely, science-based information. This includes working with the media, populations served and getting the right message to the right people. There are five activities within this standard.

**10A NCAC 48D .0204 Standard D: Emergency Preparedness & Response**
This standard measures the LHDs capacity to respond to emergencies of all kinds – from natural disasters to bioterrorist attacks. This looks at the public health responsibilities in planning and responding to a disaster. There are five activities within this standard.

**10A NCAC 48D .0205 Standard E: Structural and Social Determinants of Health**
This standard measures the LHDs capacity to address social and structural determinants of health through policy, programs, and services, strategic priorities and accountability metrics. There are three activities within this standard.

**10A NCAC 48D .0206 Standard F: Organizational Workforce Development**
This standard measures the LHDs capacity to hire and retain a qualified workforce through human resource functions and policies. This includes how the department develops the skills and abilities of staff, including leadership and front-line. There are four activities within this standard.

**10A NCAC 48D .0207 Standard G: Organizational Leadership, Governance, & Legal Services**
This standard measures the LHDs capacity to lead internal and external stakeholders to consensus and action, having access to legal counsel and services, and having a Board of Health that is knowledgeable of its roles and responsibilities. There are five activities within this standard.

**10A NCAC 48D .0208 Standard H: Organizational Facilities**

This standard measures the LHDs capacity to have access to the facilities needed to provide services. This includes having a clean, safe and accessible space for employees, visitors and clients, having equipment that is properly maintained and improving facilities as indicated to meet laws on public access. There are four activities within this standard.

**10A NCAC 48D .0209 Standard I: Organizational Finance and IT**
This standard measures the LHDs capacity to follow proper finance protocols, participate in a financial audit process, operate based on standard practices, confidentiality of records and information technology systems needed for services and department functions. There are three activities within this standard.

**10A NCAC 48D .0210 Standard J: Accountability & Performance Management**
This standard measures the LHDs capacity to apply business practices that assure efficient use of resources to achieve desired outcomes while fostering continuous learning and quality improvement. There are five activities within this standard.

**10A NCAC 48D .0211 Standard K: Policy Development & Support**
This standard measures the LHDs capacity to enforce laws and regulations, to develop and provide input in needed laws and the ability to review laws in comparison to accepted public health practice. It also includes the capacity to develop policy for the department and the community based on identified needs. There are three activities within this standard.

## Impact Analysis

### *State Government Impact*

The proposed repeal of the existing accreditation rules (10A NCAC 48A and 48B) and adoption of new accreditation rules (10A NCAC 48C and 48D) is expected to result in one-time costs in the near term and long-term benefits to state government.

**Costs**

*DPH Impact*

There are no direct costs to NCDHHS or DPH with the rules change. DPH does offer support in providing documentation to LHDs of satisfaction of activities. This will not change under the new rules; however, the restructuring of accreditation activities and accreditation processes is expected to streamline the asks made to DPH and, therefore, may reduce the frequency of communication and amount of documentation necessary. The overall impact is expected to be a slight reduction in time and effort for DPH staff.

*NCIPH Impact*

While the long-term impact of the new rules is expected to create opportunity cost savings for NCIPH, there are Program costs related to the initial implementation of rule changes. There would need to be an initial investment of staff time and funds in revising accreditation guidance and interpretation documents, including guidance documents, operational guidelines, the self-assessment Dashboard, and interpretation guidelines. This would include meetings with staff, workgroups, and Board committees.

The provision of training and ongoing training costs will be neutral with the new rules. Currently, all accreditation education is developed and provided by Program staff at NCIPH. Annual trainings that are

provided to LHDs and to various roles involved in the accreditation process include sessions on using the documentation portal, site visitor responsibilities, reaccreditation preparation, annual updates and Agency Accreditation Coordinator responsibilities. There is regular turnover in Agency Accreditation Coordinators, requiring training in the current process for these staff. This would not change with the new rules. The training materials are updated annually by Program staff. Most trainings are recorded and posted on the NCIPH website to be used as refreshers and for LHD staff to view for just-in-time education. Trainings are a benefit of the fees paid by the LHDs. However, there will be an initial opportunity cost to update trainings and materials to reflect the rule changes and new compliance processes.

NCIPH staff will need to devote additional staff time to initially update Program materials and training materials as described above to align with the new rules. While Program staff regularly update materials, the initial transition will take up a portion of time for several Program staff at an estimated opportunity cost of $70,320.

**Estimated NCIPH Staff FTE Allocations and Salary Costs for Program Updates and Training**

| Role | FTE | Salary ($) | Fringe ($) | Total ($) |
|---|---|---|---|---|
| Accreditation Administrator | 0.10 | 9,495 | 4,187 | 13,682 |
| Accreditation Coordinator | 0.15 | 9,471 | 4,583 | 14,054 |
| Project Manager | 0.10 | 7,726 | 3,558 | 11,284 |
| Policy Analyst | 0.25 | 18,750 | 8,693 | 27,443 |
| Phase 3 Coordinator | 0.15 | 3,523 | 334 | 3,857 |
| | | | **TOTAL** | **$70,320** |

In addition, it is expected that there may be a slight reduction in total site visitor costs in the long term, as the rules reduce the required number of site visitors from four to three. Each site visitor is assigned a subset of accreditation activities to review, according to their area of expertise prior to a site visit. Each site visit lasts for 6-7 hours on average, where the site visitors review personnel records, conduct LHD interviews, tour the facility(ies), and review and respond to additional evidence. Following the site visit, site visitors formalize their recommendation in a report. The lead site visitor presents the report at the Board adjudication meeting. The lead site visitor is paid $525 per site visit. Each standard site visitor is paid $325 per site visit. This would be a reduction of one standard site visitor and, therefore, could result in up to $27,950 ($325 x 86 LHDs) over 4 years or about $6,987 per year. Actual savings are unlikely to be quite that high, as sometimes four site visitors may still be needed, depending on the expertise of those who express interest and are selected to participate. Savings in funding will be available for use in other parts of the Program.

While transitioning from the current rules to the new rule requirements, site visitors will need additional training to orient to the new requirements. Initial training on the new rules is expected to take place in person in Chapel Hill, NC, and NCIPH will offer one-time travel reimbursement to a team of about 25 site visitors across the state. Based on a general understanding of where site visitors reside across the state, an estimated average of about 200 miles roundtrip, and an assumption of the mileage reimbursement rate of $0.70/mile, travel reimbursement is expected to cost approximately $3,500. This was calculated as follows:

25 site visitors * 200 miles round trip * $0.70/mile reimbursement = $3,500

This amount is a cost that will be paid from LHD fees. All site visitors are independent consultants who sign an agreement to attend annual mandated training as a part of their commitment with NCIPH.

**Benefits**

After the initial investment described above, it is expected that there will be a slight decrease in the amount of NCIPH and DPH staff time due to the streamlined accreditation processes described in 48C and the reduction in accreditation activities described in 48D. It is anticipated that this will result in fewer questions from LHDs on how to implement activities and less time spent on emails, calls, and office hours. Most calls and emails seek clarification on timeframes, personnel requirements, and governance. 48C and 48D rules streamline these topics and allow for clearer Program communications moving forward. This will allow staff to focus on other priorities. While we do not have specific data on the time currently spent responding to these types of questions, it is anticipated that any resulting time savings for NCIPH and DPH staff will likely be modest.

**Summary of Estimated State Government Impacts** (rounded)

| | |
|---|---|
| **One-Time Costs** | |
| NCIPH staff time for updating accreditation materials | $70,000 opportunity cost |
| Travel for Site Visitor training | $3,500 |
| **Ongoing Cost Savings** | |
| Reduction in required number of Site Visitors per Team | Up to $7,000/year |
| Reduction in staff time providing technical assistance | Unquantifiable, but modest opportunity cost savings |

## ***Local Government Impact***

The proposed repeal of the existing accreditation rules (10A NCAC 48A and 48B) and adoption of new accreditation rules (10A NCAC 48C and 48D) is expected to result in short-term opportunity costs and long-term benefits to local government.

**Costs**

*Local Health Department Impact*

Each LHD has an AAC who coordinates an agency's accreditation evidence and serves as a point person between the Program and the LHD. AACs will need to be trained on the new rule requirements and will also need to make changes to the way accreditation materials are collected and organized. Most AACs already participate in annual training opportunities, so this is not expected to substantially increase the amount of time that AACs spend on training. Trainings are available online and free of cost. Based on experience, it is estimated that updating internal accreditation protocols and reorganizing accreditation materials to match the new rule structure will take the AAC in each LHD approximately 20-30 hours. The job classifications and salaries of AACs vary widely across LHDs. Based on the positions typically assigned

as AACs, the hourly rate of compensation (salary + fringe) is averaged at an estimated $35.43.[2] Assuming one AAC per LHD, this would result in a total one-time opportunity cost of between $60,940 to $91,409 across all 86 LHDs. While this estimated range provides a baseline with which to consider the likely impacts, the actual costs could be higher or lower and will vary due to factors such as differences in pay rates and the number of staff sharing AAC responsibilities at a given LHD. In any case, the one-time opportunity cost is expected to be more than offset by future time savings for AACs in gathering and organizing documentation due to reduced and streamlined accreditation activities. This is discussed under the benefits section.

**Estimated One-Time Total Opportunity Cost Across 86 LHDs to Update Accreditation Materials**

| | |
|---|---|
| Average Hourly Rate per AAC (salary + fringe) | $35.43 |
| Hours per AAC to update protocols and materials | 20 to 30 hours |
| Number of AACs | 86 (assumes 1 per LHD) |
| **Total One-Time Opportunity Cost** | **$60,940 to $91,409** (Rate x Hours) x 86 AACs |

**Benefits**

One of the biggest costs to LHDs for completing the accreditation process is the dedication of staff time. The streamlining and reduction of accreditation activities is expected to require LHD staff to spend less time tracking accreditation activities and collecting and organizing documentation. This staff time can be dedicated to the other job functions and activities.

In addition, it is often challenging for LHDs to retain staff in the AAC role. Based on Program records, since 2022, 55% of LHDs have had turnover in their AAC roles, which is not surprising given the demanding nature of these positions. Often AACs wear additional hats within an LHD, such as administrative support, business support, quality improvement coordination, and more. AACs have been integral to providing feedback on new proposed rules, and the rules have been designed to address many of the concerns raised. These changes may enable LHDs to retain AAC staff in their roles for longer periods of time, reducing staff time spent on hiring and training.

Based on information gathered from AACs, each AAC spends an estimated 20-30 hours a month on accreditation efforts in non-accreditation years and up to 40 hours a month during the year on their accreditation site visit. Based on these numbers and the four-year accreditation cycle, AACs spend on average 300 hours in non-accreditation years (avg 25 hrs per month x 12 months) and upwards of 480 hours in accreditation years (avg 40 hrs per month x 12 months). This would not include other staff that support the AAC and help with documentation.

Cutting accreditation activities from 147 to 45 is a more than 50% reduction in activities and is conservatively estimated to result in at least a 50% decrease in the time that AACs spend on accreditation activities. As discussed above, the reduction in activities shifts the focus of accreditation from building

[2] This average was estimated by combining the average of the lowest and highest hourly rates of a Health Educator I and a Public Health Nurse salary according to the UNC School of Government's County Salary Survey for 2023, which is available at: https://www.sog.unc.edu/publications/reports/county-salaries-north-carolina-2023, including 32.8% fringe. This calculation is shown in full on page 11. A random selection of 10 AAC salaries from 2023 according to GovSalaries.com resulted in a similar estimate ($37/hour including fringe).

capacity to improving performance and eliminates duplicative requirements. The new activities are a mixture of existing activities that have been streamlined and new activities that reflect elements from new public health frameworks, including the Foundational Public Health Services (FPHS) Framework. This would result in AACs spending an estimated 10-15 hours fewer per month in years between accreditation and an estimated 20 hours per month fewer in years where accreditation is assessed. In total, the potential time saved is estimated at 150 hours in non-accreditation years and 240 hours in accreditation years per AAC.

The job classifications and salaries of AACs vary widely across LHDs as does the structure of LHD accreditation support. In the experience of the Program, the individuals in AAC roles range from administrative staff to human services staff, to communications and operations staff to health educators to nurses. For example, Surry County has a Public Health Nurse II currently serving in this role. A public health nurse salary in an LHD has a range of approximately $45,000 to $78,000 per year[3] plus 32.8% in fringe.[4] Foothills District has a Public Health Educator II currently serving in this role. A Health Educator I salary in an LHD ranges from approximately $33,000 to $63,000[5] plus 32.8% in fringe.[6] In addition to an AAC, some LHDs provide additional support staff for accreditation. This impacts the amount of time spent by some AACs, especially those in higher level positions within the LHD, who may rely on administrative support staff to assist with accreditation activities. AACs also have a range of participation in voluntary accreditation activities, such as peer support and work groups and training activities, based on interest and availability. The amount of time devoted to and process of preparing for accreditation looks different in each LHD. For purposes of this fiscal note, we made the assumption that a typical AAC salary falls between the lowest county salary and highest county salary listed in this paragraph and computed an hourly compensation rate, including a fringe of 32.8%, of $35.43.

Lowest Salary + Fringe: $33,000 + (33,000 * 0.328) = $43,824

Highest Salary + Fringe: $78,000 + (78,000 * 0.328) = $103,584

Average Salary + Fringe: (43,824 + 103,584) / 2 = $73,704

**Estimated Hourly Rate of an AAC (assuming 2,080 hours/year) = $35.43**

Time savings achieved will be spread across the four-year accreditation cycle. There are two cohorts of LHDs that are assessed for accreditation in each year with 6-15 LHDs in each cohort.[7] For this reason, the higher savings in accreditation years will be spread across the 86 LHDs across four years. Based on these assumptions, there is an estimated annual cost saving between $514,511 - $546,402 or approximately

[3] The average Public Health Nurse II salary was estimated using the UNC School of Government's County Salary Survey for 2023, which is available at: https://www.sog.unc.edu/publications/reports/county-salaries-north-carolina-2023 .

[4] The value of benefits was identified using the U.S. Bureau of Labor Statistics' latest available figures from December 2024 on employer costs for employee compensation for state and local government workers, which is available at: https://www.bls.gov/news.release/ecec.t03.htm .

[5] The average Health Educator I salary was estimated using the UNC School of Government's County Salary Survey for 2023, which is available at: https://www.sog.unc.edu/publications/reports/county-salaries-north-carolina-2023. There are no Health Educator II salaries included in the survey.

[6] The value of benefits was identified using the U.S. Bureau of Labor Statistics' latest available figures from December 2024 on employer costs for employee compensation for state and local government workers, which is available at: https://www.bls.gov/news.release/ecec.t03.htm .

[7] NC LHD Accreditation Board. "NC Local Health Department Accreditation Cycle Schedule". https://nclhdaccreditation.unc.edu/wp-content/uploads/sites/733/2024/12/Accreditation-Cycle-Schedule-2025.pdf. Accessed 7 April 2025.

$6,000 per LHD per year. These cost savings will allow LHDs to leverage the time of their AAC and other administrative staff supporting accreditation in other ways.

**Estimated Ongoing Local Government Opportunity Cost Savings per Year**

| | Y1 (FY27) | Y2 (FY28) | Y3 (FY29) | Y4 (FY30) |
|---|---|---|---|---|
| # LHDs in an Accreditation Year | 28 | 18 | 20 | 20 |
| # LHDs in a Non-Accreditation Year | 58 | 68 | 66 | 66 |
| # Hours Saved in an Accreditation Year | 6,720 | 4,320 | 4,800 | 4,800 |
| # Hours Saved in a Non-Accreditation Year | 8,700 | 10,200 | 9,900 | 9,900 |
| $ Saved from LHDs in Accreditation Years | $238,121 | $153,078 | $170,086 | $170,086 |
| $ Saved from LHDs in Non-Accreditation Years | $308,281 | $361,433 | $350,803 | $350,803 |
| **Total # Hours Saved Statewide** | **15,420** | **14,520** | **14,700** | **14,700** |
| **Total LHD Savings** | **$546,402** | **$514,511** | **$520,889** | **$520,889** |

*Cost savings are calculated using the hourly rate ($35.43) derived from the salary range (assuming 2,080 work hours/year) and applying the 50% time reduction. Fringe benefits (32.8%) are included.
*Years are based on the current accreditation schedule.[8]

- Hourly Rate: $35.43 (derived from average salary range + 32.8% fringe). Hourly rate is in 2025$ and not adjusted for inflation.
- Non-Accreditation Years: LHDs save 150 hrs/year; Accreditation Years: LHDs save 240 hrs/year.
- Savings are spread across 86 LHDs, with 18-28 LHDs assessed annually.
- Assumes one AAC per LHD.
- Reductions stem from cutting accreditation activities by over 50% (from 147 to 45 activities).
- Freed-up time can be redirected to other public health priorities.

**Summary of Estimated Local Government Impacts** (rounded)

| | |
|---|---|
| **One-Time Opportunity Costs, Year One** | |
| AAC time spent updating accreditation materials | $61,000 to $91,000 |
| **Average Annual Opportunity Cost Savings** | |
| Reduced AAC time spent on accreditation activities | $515,000 to $546,000 |

[8] NC LHD Accreditation Board. "NC Local Health Department Accreditation Cycle Schedule". https://nclhdaccreditation.unc.edu/wp-content/uploads/sites/733/2024/12/Accreditation-Cycle-Schedule-2025.pdf. Accessed 7 April 2025.

***Public Health Impact***

The proposed rule changes are expected to bring meaningful, though relatively modest, improvements to public health in North Carolina. The majority of the benefits to the public will continue to come from the ongoing implementation of the existing Program. There is evidence that suggests that accreditation of health departments is associated with improvements in organizational performance, quality improvement, accountability, and the adoption of evidence-based practices.[9] While these process improvements are documented, direct evidence linking accreditation to improved population-level health outcomes has been challenging to demonstrate.

The proposed changes will update the existing LHD accreditation standards to be aligned with current best practices and focus on quality improvement. The updated activities are expected to encourage LHDs to make better use of public health data to inform their programs and services, to strengthen plans and partnerships, and to adopt a mindset of continuous quality improvement. Due to the completion of accreditation activities, health departments are more likely to be better equipped to serve their communities and to have strong plans, procedures, and partnerships in place when emergency situations arise.[10,11] This should provide an ongoing benefit to the communities LHDs serve and to the health and wellness of the North Carolinians across the state.

**Alternatives**

Although the agency has determined that the proposed rules will not have a "substantial economic impact" as defined in G.S. 150B-21.4, two alternative approaches were considered and are presented below to offer additional context.

One alternative that was considered was maintaining the status quo and not making these updates to the LHD accreditation process and standards. The accreditation standards that were adopted in 2006 were designed to help LHDs build capacity to provide high quality public health services in a standardized way. Now that all LHDs have been accredited and reaccredited, the initial capacity has been well established and reviewed and there is an opportunity to update the framework to better reflect current practices and focus on improving performance. Continuing to maintain the existing standards would have a diminishing return for public health over time and also not be responsive to the many ideas that LHDs have lifted up to streamline and improve the Program. In addition, it would forgo the opportunity to make the Program more efficient and less resource intensive for state and local government. Consultation with the Board and feedback from LHD staff via informal public comment periods reinforced the need to update rule language. For these reasons, this alternative was not pursued.

A second alternative considered was to take a lighter touch approach to the updates, keeping processes and standards more similar to the current rules. For example, this could have included maintaining 4 site visitors (rather than moving to 3), retaining the current scoring structure (rather than moving to tiered scoring), or more closely aligning accreditation standards with the current structure (3 standards with 41 benchmarks

[9] Kronstadt J, Meit M, Siegfried A, Nicolaus T, Bender K, Corso L. Evaluating the Impact of National Public Health Department Accreditation — United States, 2016. MMWR Morb Mortal Wkly Rep 2016;65:803–806. DOI: http://dx.doi.org/10.15585/mmwr.mm6531a3

[10] Exploring the Linkage Between Accreditation Outcomes and Public Health Emergency Preparedness and Response; Kennedy, Heffernan, et.al.; Journal of Public Health Management and Practice. 28(1):E80-E84, January/February 2022.

[11] Accreditation and Emergency Preparedness Linkages and Opportunities for Leveraging the Connections; Singleton, Corso, et.al.; Journal of Public Health Management and Practice 20(1):p 119-124, January/February 2014.

comprised of activities rather 11 standards comprised of activities). Lighter touch changes would have been helpful as compared to the status quo, but would not maximize opportunities for efficiency and cost savings nor align with current public health frameworks and the focus on performance improvement. For these reasons, this alternative was not pursued and more comprehensive updates are proposed instead.

## Appendix A: Comparison of Current and Proposed Activities

| Standard A: Assessment & Surveillance | | | |
|---|---|---|---|
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |
| .0201(1) | a community health assessment | .0201(b)(1) Community Health Assessment<br>.0201(b)(3) CHA and SOTCH Dissemination | e.2.a: Monitoring health status to identify community health problems. |
| .0201(2) | collect and use a minimum of two sources of data to document the health of the population and identify communities with barriers accessing health care | .0203(b)(1) Health-Related Data Expertise<br>.0301(b)(1) Community Health Surveillance<br>.0301(b)(2) Environmental Health Risks<br>.0301(b)(3) Epidemiologist Expertise | e.2.a: Monitoring health status to identify community health problems.<br>e.2.b: Diagnosing and investigating health hazards in the community. |
| .0201(3) | collect and use a minimum of two sources of data to guide LHD programs and services | .0203(b)(1) Health-Related Data Expertise<br>.0301(b)(1) Community Health Surveillance<br>.0301(b)(2) Environmental Health Risks<br>.1001(b)(1) Customer and Community Satisfaction<br>.1001(b)(2) Satisfaction Data Evaluation and Implementation | e.2.a: Monitoring health status to identify community health problems. |
| .0201(4) | provide, contract for the provision of, or assure the availability of laboratory services for disease detection in the jurisdiction | .0305(b)(1) Laboratory Samples<br>.0305(b)(2) Laboratory Compliance<br>.0305(b)(3) Access to Laboratory Services<br>.0305(b)(4) Laboratory Services for Problems/Hazards/Emergencies | e.2.b: Diagnosing and investigating health hazards in the community. |
| .0201(5) | monitor emerging health issues and threats and report communicable diseases in accordance with 10A NCAC 41A .0103 | .0202(b)(3) Communicable Disease Reporting<br>.0202(b)(4) Reportable Event Surveillance<br>.0301(b)(1) Community Health Surveillance<br>.0301(b)(2) Environmental Health Risks | e.2.a: Monitoring health status to identify community health problems.<br>e.2.b: Diagnosing and investigating health hazards in the community. |
| **Standard B: Community Partnership Development** | | | |
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |
| .0202(1) | consult with representatives of communities with barriers accessing health care in developing and implementing LHD programs and services | .0501(b)(1) Collaboration to Identify Health Issues and Needs<br>.0501(b)(2) Community Member Involvement in Priority Setting and Outcome Goals | e.2.d: Mobilizing community partnerships to identify and solve health problems.<br>e.2.g: Linking people to needed personal health care services and assuring the provision of health |

| | | | |
|---|---|---|---|
| | | .0803(b)(4) Community Health Advocates | care when otherwise unavailable. |
| .0202(2) | develop and maintain relationships with community partners and government entities to improve LHD programs and services | .0501(b)(1) Collaboration to Identify Health Issues and Needs<br>.0501(b)(2) Community Member Involvement in Priority Setting and Outcome Goals<br>.0502(b)(1) Collaboration to Identify Strategies<br>.0503(b)(1) Community Contact Awareness of Public Health | e.2.d: Mobilizing community partnerships to identify and solve health problems. |
| .0202(3) | consult community partners in the development of the community health improvement plan | .0501(b)(2) Community Member Involvement in Priority Setting and Outcome Goals<br>.0502(b)(2) Collaboration to Assess Resource Needs<br>.0502(b)(3) Collaboration to Implement Population-Based Programs<br>.0804(b)(1) Community Health Improvement Plans | e.2.d: Mobilizing community partnerships to identify and solve health problems.<br>e.2.g: Linking people to needed personal health care services and assuring the provision of health care when otherwise unavailable. |
| **Standard C: Communications** | | | |
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |
| .0203(1) | develop a plan for communicating public health information to the population and demonstrate using the plan | .0302(b)(3) Health Alerts to News Media<br>.0401(b)(1) Current Health Issue Communication<br>.0401(b)(5) Departmental Change Communication | e.2.c: Informing, educating, and empowering people about health issues. |
| .0203(2) | tailor communications to reach communities and distribute the communications to those communities | .0401(b)(6) Cultural and Linguistic Character Reflected<br>.0402(b)(2) Health Promotion/Disease Prevention for At-Risk Groups | e.2.c: Informing, educating, and empowering people about health issues. |
| .0203(3) | share data about the health of the population with the public and community partners | .0202(b)(1) Vital Records<br>.0401(b)(1) Current Health Issue Communication<br>.0401(b)(2) Public Community Data Access<br>.0401(b)(3) Availability and Location of Health Data in Public Domain | e.2.a: Monitoring health status to identify community health problems.<br>e.2.c: Informing, educating, and empowering people about health issues. |
| .0203(4) | develop partnerships with the media and promote public health messages through those partnerships | .0401(b)(1) Current Health Issue Communication | e.2.c: Informing, educating, and empowering people about health issues. |

| | | | |
|---|---|---|---|
| .0203(5) | develop and implement a plan to educate the population on public health topics | .0402(b)(1) Health Promotion/Disease Prevention for General Public<br>.0402(b)(2) Health Promotion/Disease Prevention for At-Risk Groups<br>.0803(b)(1) Community Resource List<br>.0803(b)(2) Agency Information | e.2.c: Informing, educating, and empowering people about health issues.<br>e.2.g: Linking people to needed personal health care services and assuring the provision of health care when otherwise unavailable. |
| **Standard D: Emergency Preparedness & Response** | | | |
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |
| .0204(1) | maintain emergency preparedness and response plans and train LHD staff on those plans | .0303(b)(2) County Emergency Operations Plan<br>.0303(b)(3) Regional Exercises/Activities<br>.0304(b)(4) All Hazards Emergency Response Plan<br>.0304(b)(6) Response Plan Testing | e.2.b: Diagnosing and investigating health hazards in the community. |
| .0204(2) | provide LHD personnel and communications systems to implement preparedness and response plans, in the event of a state of emergency declaration under G.S. 166A-19.3(19), a disaster declaration under G.S. 166A-19.3(3), or a disaster declaration under 44 C.F.R. Part 206, Subpart B in coordination with government entities and community partners | .0302(b)(2) Health Alerts to Medical Community<br>.0302(b)(3) Health Alerts to News Media<br>.0303(b)(1) LEPC Participation<br>.0304(b)(5) Local Emergency Manager Communication<br>.0304(b)(7) Epi Team | e.2.b: Diagnosing and investigating health hazards in the community. |
| .0204(3) | maintain LHD continuity of operations in the event of a declared emergency or disaster, as set out in paragraph (2) of this Rule | None | e.2.b: Diagnosing and investigating health hazards in the community. |
| .0204(4) | exercise the powers and duties of the local health director pursuant to G.S. 130A-41 | .0702(b)(3) Communicable Disease Legal Compliance<br>.0703(b)(1) Legal Enforcement Policies & Procedures<br>.0703(b)(2) Legal Enforcement Actions | e.2.f: Enforcing laws and regulations that protect health and ensure safety. |
| .0204(5) | maintain a written plan that describes how to reach the LHD by phone, email, or other form of communication 24 hours per day, seven days per week | .0302(b)(1) 24/7 Reporting System | e.2.b: Diagnosing and investigating health hazards in the community. |
| **Standard E: Structural and Social Determinants of Health** | | | |

| Rule | Proposed Activity Language from 10A NCAC 48D | Corresponding Current Activities in 10A NCAC 48B | Statutory Requirement – G.S. 130A-34.1 |
|---|---|---|---|
| .0205(1) | develop a plan that addresses structural or social determinants of health in the population | .0801(b)(1) At-Risk Population Access | e.2.e: Developing policies and plans that support individual and community health efforts. |
| .0205(2) | provide training to the LHD's workforce on structural or social determinants of health | .0902(b)(1) Staff Training Access Policies<br>.0904(b)(3) Cultural Sensitivity & Competency Training | e.2.h: Assuring a competent public health workforce and personal health care workforce.<br>e.4: The local health department's staff competencies and training procedures or programs. |
| .0205(3) | implement the plan to address structural or social determinants of health in the LHD's programs and services | none | e.2.e: Developing policies and plans that support individual and community health efforts. |
| **Standard F: Organizational Workforce Development** | | | |
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |
| .0206(1) | comply with applicable state and local human resource laws and policies related to local health department employee grievances, performance reviews, and job qualifications | .0602(b)(5) Staff Orientation on Policies and Procedures<br>.0701(b)(1) Ongoing Public Health Law Training<br>.0701(b)(2) New Staff Orientation on Laws and Rules<br>.0701(b)(3) Environmental Health Legal Training<br>.0901(b)(1) Qualified Health Director<br>.0901(b)(2) Certified and Licensed Staff<br>.0901(b)(3) Qualified Medical Director<br>.0902(b)(3) Staff Orientation and Continuing Education<br>.1201(b)(5) OSHA Regulation Compliance<br>.1202(b)(3) Disciplinary/Grievance/Harassment Policy<br>.1202(b)(4) Position Descriptions<br>.1202(b)(5) Performance Appraisal System | e.2.e: Developing policies and plans that support individual and community health efforts.<br>e.2.h: Assuring a competent public health workforce and personal health care workforce.<br>e.3: The local health department's facilities and administration. |
| .0206(2) | develop and implement a workforce development plan to recruit and retain employes who meet LHD job qualifications | .0701(b)(1) Ongoing Public Health Law Training<br>.0902(b)(2) Staff Development Plan<br>.0904(b)(1) Non-discrimination Policy<br>.0904(b)(2) Management Team Recruitment and Retention Policy | e.2.f: Enforcing laws and regulations that protect health and ensure safety.<br>e.2.h: Assuring a competent public health workforce and personal health care workforce. |

| | | | |
|---|---|---|---|
| .0206(3) | review the workforce development plan to identify and implement improvements to the plan | .0902(b)(2) Staff Development Plan | e.2.h: Assuring a competent public health workforce and personal health care workforce.<br>e.4: The local health department's staff competencies and training procedures or programs. |
| .0206(4) | provide professional development to members of the LHD's workforce, including opportunities for on-the-job training and continuing education | .0902(b)(1) Staff Training Access Policies<br>.0903(b)(1) Academic Training Opportunities | e.2.h: Assuring a competent public health workforce and personal health care workforce.<br>e.4: The local health department's staff competencies and training procedures or programs. |
| **Standard G: Organizational Leadership, Governance, & Legal Services** | | | |
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |
| .0207(1) | share public health updates with elected officials and community partners | .0601(b)(1) Informing Officials of Public Health Needs<br>.1307(b)(1) BOH Communication on Public Health Issues | e.2.e: Developing policies and plans that support individual and community health efforts.<br>e.5: The local health department's governance and fiscal management |
| .0207(2) | develop and maintain a strategic plan that sets out the LHD's priorities for the LHD's services, programs, and initiatives | .0602(b)(1) Agency Strategic Plan | e.2.e: Developing policies and plans that support individual and community health efforts. |
| .0207(3) | educate members of the LHD's Board of Health on their roles, responsibilities, and legal authority | .1301(b)(1) BOH Operating Procedures<br>.1302(b)(1) BOH Adjudication Procedures<br>.1303(b)(1) BOH Handbook<br>.1303(b)(2) BOH New Member Training<br>.1303(b)(3) BOH Ongoing Member Training<br>.1307(b)(2) BOH Support of Public Health Laws and Rules | e.5: The local health department's governance and fiscal management |
| .0207(4) | access and use legal services | .1301(b)(2) BOH Access to Legal Counsel<br>.1301(b)(3) BOH Procedures for Adopting Rules/Ordinances<br>.1301(b)(4) BOH Evaluation of Need for Rule/ Ordinance Adoption/Amendment | e.5: The local health department's governance and fiscal management |
| .0207(5) | develop and implement a plan to include community partners on public health boards, councils, or groups | .0801(b)(2) Linguistic and Cultural Representation | e.2.g: Linking people to needed personal health care services and assuring the provision of health care when otherwise unavailable. |

| Standard H: Organizational Facilities | | | |
|---|---|---|---|
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |
| .0208(1) | maintain facilities used for LHD programs and services | .1201(b)(2) Accessible Facilities<br>.1201(b)(8) Hours of Operation | e.3: The local health department's facilities and administration. |
| .0208(2) | develop and maintain written protocols for the security of LHD facilities | .1201(b)(1) Clean, Safe & Secure Facilities<br>.1201(b)(3) Client Privacy Protections | e.3: The local health department's facilities and administration. |
| .0208(3) | develop and maintain clinical and environmental health equipment in accordance with manufacturers' requirements | .1201(b)(6) Cleaning/Disinfection/Maintenance of Equipment<br>.1202(b)(6) Equipment Inventory and Replacement Plan | e.3: The local health department's facilities and administration. |
| .0208(4) | implement tobacco-free policies in LHD facilities | .1201(b)(9) Tobacco-Free Facility<br>.1201(b)(10) Tobacco-Free Grounds | e.3: The local health department's facilities and administration. |
| **Standard I: Organizational Finance and Information Technology** | | | |
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |
| .0209(1) | develop and maintain a budgeting, auditing, billing, and financial policy | .1204(b)(2) Approved Budget<br>.1204(b)(3) Accounting Principles Compliance<br>.1204(b)(4) Financial Checks and Balances<br>.1204(b)(6) Financial Reports<br>.1306(b)(2) BOH Review of Fiscal Reports<br>.1306(b)(3) BOH Approval of Fees | e.3: The local health department's facilities and administration.<br>e.5: The local health department's governance and fiscal management |
| .0209(2) | evaluate the LHD's finances and identify opportunities to secure additional funding to support LHD programs and services | .1204(b)(1) Local Appropriations<br>.1306(b)(1) BOH Support of Securing Funding | e.3: The local health department's facilities and administration.<br>e.5: The local health department's governance and fiscal management |
| .0209(3) | maintain policies and procedures that comply with the privacy and security standards required by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, and its implementing regulations, as applicable. | .1201(b)(4) Private & Secure Medical Records<br>.1203(b)(4) Management Information System Security | e.3: The local health department's facilities and administration. |
| **Standard J: Accountability & Performance Management** | | | |
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |

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|---|---|---|---|
| .0210(1) | develop and maintain written policies and procedures for the administration of the LHD | .0602(b)(2) Program Policies and Procedures<br>.0602(b)(3) Policy Review and Revision<br>.0602(b)(4) Assessment of Policy/Procedure Resources<br>.0602(b)(6) Accessibility of Policies and Procedures<br>.1202(b)(1) Administrative Policies and Procedures<br>.1304(b)(2) BOH Administrative Policy Approval | e.2.e.: Developing policies and plans that support individual and community health efforts.<br>e.3: The local health department's facilities and administration.<br>e.5: The local health department's governance and fiscal management |
| .0210(2) | comply with state and local laws and rules relating to programs and services offered by the LHD | .0702(b)(1) Environmental Health State Program Review<br>.0702(b)(2) Environmental Health Local Program Review<br>.0804(b)(2) Health Services State Program Review<br>.0804(b)(3) Health Services Local Program Review | e.2.f: Enforcing laws and regulations that protect health and ensure safety.<br>e.2.g: Linking people to needed personal health care services and assuring the provision of health care when otherwise unavailable. |
| .0210(3) | maintain a procedure for monitoring and improving the performance of LHD programs and services | none | e.2.i: Evaluating effectiveness, accessibility, and quality of personal and population-based health services. |
| .0210(4) | identify and use evidence-informed practices to improve LHD programs and services | .0402(b)(3) Evidence-Based Promotion and Prevention Strategies<br>.0402(b)(4) Community Support for Evidence Based Strategies<br>.0903(b)(2) Academic Research and Evaluation of Programs<br>.1101(b)(1) Program Effectiveness Review | e.2.c: Informing, educating, and empowering people about health issues.<br>e.2.h: Assuring a competent public health workforce and personal health care workforce.<br>e.2.i: Evaluating effectiveness, accessibility, and quality of personal and population-based health services.<br>e.2.j: Conducting research. |
| .0210(5) | use quality improvement practices to improve LHD services and programs | .1001(b)(3) Quality Assurance and Improvement | e.2.i: Evaluating effectiveness, accessibility, and quality of personal and population-based health services. |
| **Standard K: Policy Development & Support** | | | |
| **Rule** | **Proposed Activity Language from 10A NCAC 48D** | **Corresponding Current Activities in 10A NCAC 48B** | **Statutory Requirement – G.S. 130A-34.1** |
| .0211(1) | enforce public health laws and rules in accordance with G.S. Chapter 130A-4 | .0304(b)(3) Environmental Health Complaints/Referrals<br>.0703(b)(1) Legal Enforcement Policies & Procedures<br>.0703(b)(2) Legal Enforcement Actions<br>.0703(b)(3) Legal Complaint Policies and | e.2.b: Diagnosing and investigating health hazards in the community.<br>e.2.f: Enforcing laws and regulations that protect health and ensure safety. |

| | | | |
|---|---|---|---|
| | | Procedures<br>.0703(b)(4) Addressing of Legal Complaints | |
| .0211(2) | make recommendations to the LHD's Board of Health on local rules or policies to improve the health of the population | .0601(b)(2) Supporting Policymakers in Priorities and Programs<br>.0601(b)(3) Evaluation of Need for Additional Rules/Ordinances<br>.0601(b)(4) Development/Presentation of New/Amended Rules/Ordinances | e.2.e: Developing policies and plans that support individual and community health efforts. |
| .0211(3) | Make recommendations to legislators or regulators regarding state laws or rules impacting public heath | .0601(b)(2) Supporting Policymakers in Priorities and Programs<br>.0601(b)(3) Evaluation of Need for Additional Rules/Ordinances<br>.0601(b)(4) Development/Presentation of New/Amended Rules/Ordinances | e.2.e: Developing policies and plans that support individual and community health efforts. |

## Appendix B: Proposed Rule Text

10A NCAC 48A .0101 - .0102 are proposed for repeal as follows:

**CHAPTER 48 - LOCAL HEALTH DEPARTMENT ACCREDITATION**

**SUBCHAPTER 48A - LOCAL HEALTH DEPARTMENT ACCREDITATION –ADMINISTRATION**

**SECTION .0100 - GENERAL PROVISIONS**

**10A NCAC 48A .0101 PURPOSE**
**10A NCAC 48A .0102 DEFINITIONS**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48A .0201 - .0205 are proposed for repeal as follows:

**SECTION .0200 - ACCREDITATION PROCESS**

**10A NCAC 48A .0201 SELF-ASSESSMENT**
**10A NCAC 48A .0202 SITE VISIT**
**10A NCAC 48A .0203 BOARD ACTION**
**10A NCAC 48A .0204 INFORMAL REVIEW PROCEDURES**
**10A NCAC 48A .0205 RE-ACCREDITATION**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .0101 - .0102 are proposed for repeal as follows:

## SUBCHAPTER 48B - LOCAL HEALTH DEPARTMENT ACCREDITATION STANDARDS

### SECTION .0100 - GENERAL PROVISIONS

**10A NCAC 48B .0101 PURPOSE**

**10A NCAC 48B .0102 DEFINITIONS**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .0103 is proposed for repeal as follows:

**10A NCAC 48B .0103 ACCREDITATION REQUIREMENTS**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Amended Eff. April 1, 2015; February 1, 2013;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .0201 - .0203 are proposed for repeal as follows:

### SECTION .0200 - MONITOR HEALTH STATUS

**10A NCAC 48B .0201 BENCHMARK 1**

**10A NCAC 48B .0202 BENCHMARK 2**

**10A NCAC 48B .0203 BENCHMARK 3**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*

*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .0301 - .0305 are proposed for repeal as follows:

**SECTION .0300 - DIAGNOSE AND INVESTIGATE HEALTH PROBLEMS AND HEALTH HAZARDS IN THE COMMUNITY**

**10A NCAC 48B .0301 BENCHMARK 4**
**10A NCAC 48B .0302 BENCHMARK 5**
**10A NCAC 48B .0303 BENCHMARK 6**
**10A NCAC 48B .0304 BENCHMARK 7**
**10A NCAC 48B .0305 BENCHMARK 8**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .0401 - .0402 are proposed for repeal as follows:

**SECTION .0400 - INFORM, EDUCATE, AND EMPOWER PEOPLE ABOUT HEALTH ISSUES**

**10A NCAC 48B .0401 BENCHMARK 9**
**10A NCAC 48B .0402 BENCHMARK 10**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .0501 - .0503 are proposed for repeal as follows:

## SECTION .0500 - MOBILIZE COMMUNITY PARTNERSHIPS TO IDENTIFY AND SOLVE HEALTH PROBLEMS

**10A NCAC 48B .0501 BENCHMARK 11**
**10A NCAC 48B .0502 BENCHMARK 12**
**10A NCAC 48B .0503 BENCHMARK 13**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .0601 - .0602 are proposed for repeal as follows:

## SECTION .0600 - DEVELOP POLICIES AND PLANS THAT SUPPORT INDIVIDUAL AND COMMUNITY HEALTH EFFORTS

**10A NCAC 48B .0601 BENCHMARK 14**
**10A NCAC 48B .0602 BENCHMARK 15**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .0701 - .0703 are proposed for repeal as follows:

## SECTION .0700 - ENFORCE LAWS AND REGULATIONS THAT PROTECT HEALTH AND ENSURE SAFETY

**10A NCAC 48B .0701 BENCHMARK 16**
**10A NCAC 48B .0702 BENCHMARK 17**

**10A NCAC 48B .0703 BENCHMARK 18**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;Repealed Eff. June 1, 2026.*

10A NCAC 48B .0801 - .0804 are proposed for repeal as follows:

## SECTION .0800 - LINK PEOPLE TO NEEDED PERSONAL HEALTH SERVICES TO ASSURE THE PROVISION OF HEALTH CARE WHEN OTHERWISE UNAVAILABLE

**10A NCAC 48B .0801 BENCHMARK 19**
**10A NCAC 48B .0802 BENCHMARK 20**
**10A NCAC 48B .0803 BENCHMARK 21**
**10A NCAC 48B .0804 BENCHMARK 22**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .0901 - .0904 are proposed for repeal as follows:

## SECTION .0900 - ASSURE A COMPETENT PUBLIC HEALTH WORKFORCE AND PERSONAL HEALTH WORKFORCE

**10A NCAC 48B .0901 BENCHMARK 23**
**10A NCAC 48B .0902 BENCHMARK 24**
**10A NCAC 48B .0903 BENCHMARK 25**
**10A NCAC 48B .0904 BENCHMARK 26**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*

*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .1001 is proposed for repeal as follows:

**SECTION .1000 - EVALUATE EFFECTIVENESS, ACCESSIBILITY AND QUALITY OF PERSONAL AND POPULATION-BASED HEALTH SERVICES**

**10A NCAC 48B .1001 BENCHMARK 27**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .1101 - .1102 are proposed for repeal as follows:

**SECTION .1100 - RESEARCH FOR NEW INSIGHTS AND INNOVATIVE SOLUTIONS TO HEALTH PROBLEMS**

**10A NCAC 48B .1101 BENCHMARK 28**
**10A NCAC 48B .1102 BENCHMARK 29**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .1201 - .1204 are proposed for repeal as follows:

**SECTION .1200 - PROVIDE FACILITIES AND ADMINISTRATIVE SERVICES**

**10A NCAC 48B .1201 BENCHMARK 30**

**10A NCAC 48B .1202 BENCHMARK 31**

**10A NCAC 48B .1203 BENCHMARK 32**

**10A NCAC 48B .1204 BENCHMARK 33**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .1301 - .1308 is proposed for repeal as follows:

**SECTION .1300 – GOVERNANCE**

**10A NCAC 48B .1301 BENCHMARK 34**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Amended Eff. April 1, 2015;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .1302 - .1303 are proposed for repeal as follows:

**10A NCAC 48B .1302 BENCHMARK 35**

**10A NCAC 48B .1303 BENCHMARK 36**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48B .1304 - .1308 are proposed for repeal as follows:

**10A NCAC 48B .1304 BENCHMARK 37**

**10A NCAC 48B .1305 BENCHMARK 38**

**10A NCAC 48B .1306 BENCHMARK 39**

**10A NCAC 48B .1307 BENCHMARK 40**

**10A NCAC 48B .1308 BENCHMARK 41**

*History Note:* *Authority G.S. 130A-34.1;*
*Temporary Adoption Eff. January 1, 2006;*
*Eff. October 1, 2006;*
*Amended Eff. April 1, 2015;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, ~~2016.~~ 2016;*
*Repealed Eff. June 1, 2026.*

10A NCAC 48C .0101 is proposed for adoption as follows:

**SUBCHAPTER 48C - LOCAL HEALTH DEPARTMENT ACCREDITATION - ADMINISTRATION**

**SECTION .0100 - GENERAL PROVISIONS**

**10A NCAC 48C .0101 PURPOSE**

The rules of this Subchapter establish the process for local health departments to become accredited pursuant to G.S. 130A-34.1.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48C .0102 is proposed for adoption as follows:

**10A NCAC 48C .0102 DEFINITIONS**

The following definitions shall apply throughout this chapter:

(1) "Accreditation" means an evaluation of an LHD's infrastructure, competence, and capacity to provide public health services through the satisfaction of the standards set out in 10A NCAC 48D Section .0200.(2) "Accreditation status" means the status assigned to an LHD by the Board in accordance with G.S. 130A-34.1 and the rules of this Subchapter. The types of accreditation status are accredited, conditionally accredited, or unaccredited.

(3) "Activity" means a task demonstrating achievement of a portion of a standard.

(4) "Board" means "Accreditation Board" as defined in G.S. 130A-2(1).

(5) "Board of Health" or "BOH" means a "local board of health" as defined in G.S. 130A-2(4), a board of county commissioners that has assumed control of a local board of health in accordance with G.S.

153A-77(a), a consolidated human services board with the authority to carry out the functions of a local board of health in accordance with G.S. 153A-77(b)(2), or hospital authority board acting pursuant to S.L. 1997-502, Sec. 12.

(6) "Community" means a subdivision of the population that shares one or more characteristics.

(7) "Community Health Assessment" means a process to identify through the collection and analysis of data and to document in a written report the public health needs within an LHD's jurisdiction.

(8) Community Health Improvement Plan" means a written document setting out the steps to address the public health needs identified in the Community Health Assessment.

(9) "Community Partner" means individuals, groups, or organizations that are not affiliated with federal, state, local, or tribal government, but work with the LHD to identify and address public health needs.

(10) "Dashboard" means the web-based portal developed and maintained by the Institute to receive self-assessments submitted by LHDs. The Dashboard is located at https://nclhdaccreditation.unc.edu/nclhda-dashboard/.

(11) "Evidence-informed practice" means a way of doing something that is based on research findings, public health data, professional public health expertise, or customer feedback.

(12) "Institute" means the North Carolina Institute for Public Health.

(13) "Jurisdiction" means the county or counties that an LHD serves.

(14) "Local health department" or "LHD" means a local health department as defined in G.S. 130A-2(5), a consolidated human services agency that includes the local health department pursuant to G.S. 153A-77(b)(3), or an agency acting under the direction of a hospital authority board acting pursuant to S.L. 1997-502, Sec. 12.

(15) "Local health director" means a local health director as defined in G.S. 130A-2(6) or appointed pursuant to G.S. 153A-77(e).

(16) "Population" means the people residing within an LHD's jurisdiction.

(17) "Self-assessment" means a written review that reflects the degree of an LHD's satisfaction of each standard and activity set out in 10A NCAC 48D Section .0200 that is completed and submitted by the LHD in accordance with 10A NCAC 48D .0201. The self-assessment shall include documentation supporting the completion of each activity.

(18) "Social or Structural Determinants of Health" or "SDOH" means the non-medical factors that impact health, well-being, and quality of life including social, economic, and political factors that generate and maintain individual health outcomes.

(19) "Standard" means a criterion to be assessed in determining an LHD's accreditation. A standard is comprised of activities.

(20) "Source of data" means quantitative or qualitative data collected by an LHD or another entity.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48C .0201 is proposed for adoption as follows:

**SECTION .0200 - ACCREDITATION PROCESS**

**10A NCAC 48C .0201 SELF-ASSESSMENT**

(a) Each LHD applying for accreditation in accordance with Rule .0205 of this Section shall complete a self-assessment in the Dashboard.

(b) The self-assessment shall include the following components:

(1) contact information for the LHD;

(2) the LHD's organizational chart;

(3) a narrative describing the LHD's population;

(4) a budget for the LHD for the current state fiscal year;

(5) the roster for the LHD's governing board;

(6) a personnel list for the LHD;

(7) the level of completion of each activity in 10A NCAC 48D Section .0200, scored in accordance with 10A NCAC 48D .0101(a); and

(8) documentation supporting the level of completion for each activity in subparagraph (6) of this paragraph.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48C .0202 is proposed for adoption as follows:

**10A NCAC 48C .0202 SITE VISIT**

(a) The Institute shall select a site visit team composed of not fewer than three individuals. Each site visit team member shall have experience in an LHD. Together the individuals on a site visit team shall have experience in all of the following areas: health administration, environmental health, public health nursing, health education, and governance of an LHD. An individual shall not be part of a site visit team for an LHD where the individual is currently employed.

(b) The site visit team shall conduct the site visit of the LHD by:

(1) reviewing the LHD's self-assessment; and

(2) speaking with LHD staff and members of the LHD's BOH.

(c) The site visit team shall assess whether the LHD has completed each activity in 10A NCAC 48D Section .0200 and prepare a written report to be shared with the Board summarizing the site visit and recommending an accreditation status based on rule 10A NCAC 48D .0101. The site visit team shall provide a copy of the report to the Institute and to the LHD within 10 business days of the conclusion of the site visit.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48C .0203 is proposed for adoption as follows:

**10A NCAC 48C .0203 BOARD ACTION**

(a) The site visit team shall present the report required by Rule .0202(c) of this Subchapter to the Board at the Board's next regularly scheduled meeting. The LHD shall have an opportunity to respond to the presentation.

(b) For each LHD site visit team report that is presented, the Board shall:

(1) assign the LHD an accreditation status in accordance with 10A NCAC 48D .0101; or

(2) defer assignment of an accreditation status in order to request additional information from the LHD.

(c) The Board may defer the assignment of accreditation status under paragraph (b)(2) of this Rule by no more than six months.

(d) The Board's assignment of an accreditation status is effective the first day of the month following the date of Board action.

(e) An accreditation status of accredited shall expire four years from the last day of the month in which the Board assigned the accreditation status. Notwithstanding the foregoing, if an LHD's last accreditation status was accredited and the Board defers assigning a new accreditation status under paragraph (b)(2) of this Rule, the LHD's accreditation status shall remain accredited until the Board assigns a new accreditation status.

(f) If a state of emergency declaration has been issued under G.S. 166A-19.3(19), a disaster declaration has been issued under G.S. 166A-19.3(3), or a disaster declaration has been made by the President of the United States under 44 C.F.R. Part 206, Subpart B naming all or part of an LHD's jurisdiction and the jurisdiction has an accreditation of status of "accredited," the Board may extend the LHD's accreditation status by up to 90 days following the end of the declaration.

(g) An accreditation status of conditionally accredited shall expire as set out in G.S. 130A-34.1(g)(2).

(h) The Board shall provide written notice to the LHD of any action taken under this Rule within 5 business days of the action.

*History Note: Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48C .0204 is proposed for adoption as follows:

**10A NCAC 48C .0204 INFORMAL REVIEW PROCEDURES**

(a) If the Board assigns an LHD the status of conditionally accredited or unaccredited, the LHD may submit a written request to the Board within 10 business days of receipt of written notice under paragraph (g) of Rule .0203 of this Section for reconsideration of the Board's decision. The written request shall describe the LHD's reasoning for how it met the requirements for accreditation as set out in in 10A NCAC 48D .0101. The request shall be submitted to NCLHDaccreditation@unc.edu.

(b) The Board shall review the LHD's request at the Board's next regularly scheduled meeting. The Board shall either affirm the LHD's assigned accreditation status or assign a new accreditation status based on the information provided.

The Board shall provide written notice to the LHD of the Board's decision within 10 business days of the Board meeting where the request is reviewed.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48C .0205 is proposed for adoption as follows:

**10A NCAC 48C .0205 APPLYING FOR ACCREDITATION**

(a) Each LHD shall apply for accreditation by completing a self-assessment in the Dashboard in accordance with Rule .0201 of this Section.

(b) If an LHD has an accreditation status of accredited or conditionally accredited, the LHD shall complete the self-assessment no later than five months before the expiration date of its accreditation status.

(c) If a county health department joins a district health department pursuant to G.S. 130A-36, the accreditation status of the district health department shall apply. If the district health department does not have an accreditation status, the district health department shall complete the self-assessment no later than five months after forming and shall assume the accreditation status that applies to fifty percent or more of the counties in the district or a status of conditionally accredited. The accreditation status assumed under this paragraph shall apply until the earlier of the Board taking action in accordance with Rule .0203 of this Section or twelve months have elapsed since formation of the district. If twelve months have elapsed since formation of the district without Board action, the district health department shall be unaccredited.

(d) If a county health department withdraws from a district health department pursuant to G.S. 130A-38, the county health department shall complete the self-assessment no later than five months after withdrawing from the district health department. The county health department shall retain the accreditation status of the district health department until the earlier of the Board taking action in accordance with Rule .0203 or twelve months elapsing since withdrawal from the district. If twelve months have elapsed since withdrawal from the district without Board action, the district health department shall be unaccredited.

(e) If an LHD timely completes the self-assessment as set out in Paragraphs (b)-(d) of this Rule, the Board shall initiate a site visit in accordance with Rule .0202 of this Section and take action in accordance with Rule .0203 of this Section before the LHD's accreditation status expires. In all other circumstances, the Board shall initiate a site visit in accordance with Rule .0202 of this Section within eight months of completion of the self-assessment and shall take action in accordance with Rule .0203 of this Section at its next regularly scheduled meeting following the site visit.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48D .0101 is proposed for adoption as follows:

**SUBCHAPTER 48D - LOCAL HEALTH DEPARTMENT ACCREDITATION - STANDARDS**

**SECTION .0100 - GENERAL PROVISIONS**

**10A NCAC 48D .0101 ACCREDITATION REQUIREMENTS**

(a) The completion of each activity in Section .0200 of this subchapter shall be scored based on the self-assessment and site visit as follows:

(1) two points shall be awarded when all of an activity is completed;

(2) one point shall be awarded when part of an activity is completed; and

(3) zero points shall be awarded when no part of an activity is completed.

(b) The Board shall assign an LHD an accreditation status of accredited if the LHD earns at least four points in each standard set out in rules .0201 through .0211 of this Subchapter and at least 81 points overall.

(c) If an LHD does not meet the criteria set out in paragraph (b) of this Rule, the Board shall assign an accreditation status of conditionally accredited or unaccredited in accordance with G.S. 130A-34.1

*History Note:* *Authority G.S. 130A-34.1;*

*Eff. June 1, 2026.*

10A NCAC 48D .0201 is proposed for adoption as follows:

**SECTION .0200 – STANDARDS AND ACTIVITIES**

**10A NCAC 48D .0201 STANDARD A: ASSESSMENT AND SURVEILLANCE**

For the assessment and surveillance accreditation standard, a local health department shall complete the following activities:

(1) a community health assessment;

(2) collect and use a minimum of two sources of data to document the health of the population and identify communities with barriers accessing health care;

(3) collect and use a minimum of two sources of data to guide LHD programs and services;

(4) provide, contract for the provision of, or assure the availability of laboratory services for disease detection in the jurisdiction; and

(5) monitor emerging health issues and threats and report communicable diseases in accordance with 10A NCAC 41A .0103.

*History Note:* *Authority G.S. 130A-34.1;*

*Eff. June 1, 2026.*

10A NCAC 48D .0202 is proposed for adoption as follows:

**10A NCAC 48D .0202 STANDARD B: COMMUNITY PARTNERSHIP DEVELOPMENT**

For the community partnership and development standard, a local health department shall complete the following activities:

(1) consult with representatives of communities with barriers accessing health care in developing and implementing LHD programs and services;

(2) develop and maintain relationships with community partners and government entities to improve LHD programs and services; and

(3) consult community partners in the development of the community health improvement plan.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48D .0203 is proposed for adoption as follows:

**10A NCAC 48D .0203 STANDARD C: COMMUNICATIONS**

To satisfy the communications standard, a local health department shall complete the following activities:

(1) develop a plan for communicating public health information to the population and demonstrate using the plan;

(2) tailor communications to reach communities and distribute the communications to those communities;

(3) share data about the health of the population with the public and community partners;

(4) develop partnerships with the media and promote public health messages through those partnerships; and

(5) develop and implement a plan to educate the population on public health topics.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48D .0204 is proposed for adoption as follows:

**10A NCAC 48D .0204 STANDARD D: EMERGENCY PREPAREDNESS AND RESPONSE**

To satisfy the emergency preparedness and response standard, a local health department shall complete the following activities:

(1) maintain emergency preparedness and response plans and train LHD staff on those plans;

(2) provide LHD personnel and communications systems to implement preparedness and response plans, in the event of a state of emergency declaration under G.S. 166A-19.3(19), a disaster declaration under G.S. 166A-19.3(3), or a disaster declaration under 44 C.F.R. Part 206, Subpart B in coordination with government entities and community partners;

(3) maintain LHD continuity of operations in the event of a declared emergency or disaster, as set out in paragraph (2) of this Rule;

(4) exercise the powers and duties of the local health director pursuant to G.S. 130A-41; and

(5) maintain a written plan that describes how to reach the LHD by phone, email, or other form of communication 24 hours per day, seven days per week.

*History Note:* *Authority G.S. 130A-34.1;*

*Eff. June 1, 2026.*

10A NCAC 48D .0205 is proposed for adoption as follows:

**10A NCAC 48D .0205 STANDARD E: STRUCTURAL AND SOCIAL DETERMINANTS OF HEALTH**

To satisfy the structural and social determinants of health standard, a local health department shall complete the following activities:

(1) develop a plan that addresses structural or social determinants of health in the population;

(2) provide training to the LHD's workforce on structural or social determinants of health; and

(3) implement the plan to address structural or social determinants of health in the LHD's programs and services.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48D .0206 is proposed for adoption as follows:

**10A NCAC 48D .0206 STANDARD F: ORGANIZATIONAL WORKFORCE DEVELOPMENT**

To satisfy the organizational workforce development standard, a local health department shall complete the following activities:

(1) comply with applicable state and local human resource laws and policies related to local health department employee grievances, performance reviews, and job qualifications;

(2) develop and implement a workforce development plan to recruit and retain employes who meet LHD job qualifications;

(3) review the workforce development plan to identify and implement improvements to the plan; and

(4) provide professional development to members of the LHD's workforce, including opportunities for on-the-job training and continuing education.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48D .0207 is proposed for adoption as follows:

**10A NCAC 48D .0207 STANDARD G: ORGANIZATIONAL LEADERSHIP, GOVERNANCE, AND LEGAL SERVICES**

To satisfy the organizational leadership, governance, and legal services standard, a local health department shall complete the following activities:

(1) share public health updates with elected officials and community partners;

(2) develop and maintain a strategic plan that sets out the LHD's priorities for the LHD's services, programs, and initiatives;

(3) educate members of the LHD's Board of Health on their roles, responsibilities, and legal authority;

(4) access and use legal services; and

(5) develop and implement a plan to include community partners on public health boards, councils, or groups.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48D .0208 is proposed for adoption as follows:

**10A NCAC 48D .0208 STANDARD H: ORGANIZATIONAL FACILITIES**

To satisfy the organizational facilities standard, a local health department shall complete the following activities:

(1) maintain facilities used for LHD programs and services;

(2) develop and maintain written protocols for the security of LHD facilities;

(3) develop and maintain clinical and environmental health equipment in accordance with manufacturers' requirements; and

(4) implement tobacco-free policies in LHD facilities.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48D .0209 is proposed for adoption as follows:

**10A NCAC 48D .0209 STANDARD I: ORGANIZATIONAL FINANCE AND INFORMATION TECHNOLOGY**

To satisfy the organizational finance and information technology standard, a local health department shall complete the following activities:

(1) develop and maintain a budgeting, auditing, billing, and financial policy;

(2) evaluate the LHD's finances and identify opportunities to secure additional funding to support LHD programs and services; and

(3) maintain policies and procedures that comply with the privacy and security standards required by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, and its implementing regulations, as applicable.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48D .0210 is proposed for adoption as follows:

**10A NCAC 48D .0210 STANDARD J: ACCOUNTABILITY AND PERFORMANCE MANAGEMENT**

To satisfy the accountability and performance management standard, a local health department shall complete the following activities:

(1) develop and maintain written policies and procedures for the administration of the LHD;

(2) comply with state and local laws and rules relating to programs and services offered by the LHD;

(3) maintain a procedure for monitoring and improving the performance of LHD programs and services;

(4) identify and use evidence-informed practices to improve LHD programs and services; and

(5) use quality improvement practices to improve LHD services and programs.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*

10A NCAC 48D .0211 is proposed for adoption as follows:

**10A NCAC 48D .0211 STANDARD K: POLICY DEVELOPMENT AND SUPPORT**

To satisfy the policy development and support standard, a local health department shall complete the following activities:

(1) enforce public health laws and rules in accordance with G.S. Chapter 130A-4;

(2) make recommendations to the LHD's Board of Health on local rules or policies to improve the health of the population; and

(3) make recommendations to legislators or regulators regarding state laws or rules impacting public heath.

*History Note:* *Authority G.S. 130A-34.1;*
*Eff. June 1, 2026.*