North Carolina Public Health Region 1

STRATEGIC PLAN

JUNE 2025

Background

The field of public health is undergoing massive shifts in western North Carolina (WNC), in North Carolina (NC), and across the nation.

Myriad challenges are converging to contribute to these shifts, including chronic underfunding, continued strain on public health systems, infrastructure, staff shortages, and waning public support and polarized public sentiment toward public health. These and other challenges are contributing to staff burnout and high turnover, leading to significant current and anticipated staffing and resource shortages for local governmental public health departments (LHDs).

LHDs in WNC are faced with many challenges in delivering care and services: challenging geography in mountainous, rural communities; difficulty providing outreach to isolated communities; lack of broadband access; lack of infrastructure; and insufficient funding. Because of these and other systemic barriers, access to safety net services is not easily accessible in WNC communities that need them the most.

In an effort to address these challenges, in 2024, local Health Directors in the eight counties of Region 1 of the NC Association of Local Health Directors built on previous public health workforce planning efforts and formalized their long-time partnership into a Collaborative.

They identified opportunities to build local public health capacity through formal cross-county public health partnership and shared resources to increase access to services. Establishing regional capacity (through staffing, shared funding, or in some other way) can support smaller LHDs with fewer resources and allow more efficient use of available funds and resources.[1]

Background

With funding support from the Health Resources and Services Administration (HRSA), and building on the 2023 Public Health Workforce Development Plan for NC Public Health Region 1,[2] the Collaborative used the Foundational Public Health Services Framework (Figure 1), which describes eight Foundational Capabilities for LHDs, and the Results-Based Accountability™ (RBA) framework to guide a year-long strategic planning process. This process was designed to establish shared context and identify key opportunities for regional collaboration across county lines to support and enhance local capacity, services and programs.

Over the course of the planning year, the Health Directors met regularly to:

- Conduct a Gaps and Opportunities Analysis to establish shared context;
- Develop this Strategic Plan, which describes the prioritized strategies; and
- Develop an accompanying Business Plan that details implementation plans for the prioritized strategies, and also establishes Collaborative structures and processes to support long-term sustainability.

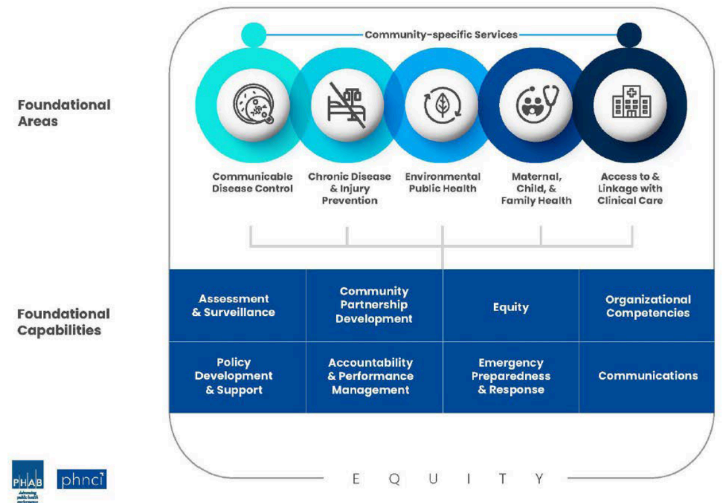


Figure 1: Foundational Public Health Services Framework (Public Health Accreditation Board).[3]

Collaborative mission *and* vision

MISSION

Strengthening public health across North Carolina Public Health Region 1 through enhanced cross-county collaboration, shared resources, and infrastructure, ensuring each local health department has the resources and capacity to effectively meet its communities' needs.

VISION

Healthy, resilient WNC communities supported by thriving, trusted local public health agencies.

What will *help*?

Context

Collaborative members identified things they know to be true that are helping OR getting in the way of supporting a regionalized approach and strategies. Additional information gathered through the Gaps & Opportunities Assessment reinforce these factors.

A regional partner organization (WNC Health Network) supports regional public health capacity for certain Capabilities through Community Health Assessment, strategic public health communications and collaborative planning.

Valuable learning and a history of working together across counties has already happened through MountainWise (a regional chronic disease prevention initiative).

Work is happening through existing partnerships and funding to advocate for including rurality in the Social Vulnerability Index.

Useful regional trainings already exist, including legal and human resources.

Partnership exists with Western Carolina University to support Environmental Health internships.

The region already has access to an experienced attorney (through Teague Campbell) who understands NC public health law and NC local government operations law.

Statewide efforts are happening to support capacity for the Foundational Capabilities locally.

NC Medicaid expansion.

Collaborative members are very used to being adaptable to emerging needs and changing priorities.

The Region 1 Workforce Development Director is an existing regional position that effectively coordinates current Region 1-wide collaborative efforts.

The region already effectively leverages existing funding for regional work (including funding from HRSA, American Rescue Plan Act (ARPA), and Dogwood Health Trust).

Regional collaboration and camaraderie among Region 1 Health Directors is already strong and supported by well-established meeting schedules and structure.

The history of Region 1 collaboration provides a foundation of trust to build more complex shared systems and reduces time needed for team-building. It also increases willingness to compromise and co-invest.

What might *get in the way?*

Many staffing gaps and vacancies exist. Existing staff are frequently performing multiple functions and may not have access to all the capacity-building support they need. This is particularly true in smaller counties and is underscored by recent health department staff focus group data.[1]

Staff salary schedules are outdated and need updating, but in North Carolina, this is largely out of the control of LHDs.

Guidance available to LHDs (through consultants or other means) for compliance and program improvement is inconsistent and sometimes contradictory. This can cause confusion and inefficiencies and could lead to non-compliance with regulations.

Different counties have different local experience, expertise and resources related to certain functions and capacities (for example, clinical billing & coding). This variability could make it harder to implement uniform regional practices across counties.

There is an overall gap in access to attorneys who understand public health.

Unintended funding consequences could result if county governments decrease their share of funding because regional/shared positions could affect local funding levels.

Additional unintended consequences could result if existing staff become overextended in their current or new roles as part of a regional model. This could affect staff morale, service quality, and retention. Loss of skilled staff could undermine institutional knowledge and program continuity if transitions aren't well managed.

Staff may not get salary increases but may have to now cover multiple counties.

Potential for lack of support for the regional model from county commissioners, county managers, and/or the state or federal government. Political or administrative resistance could block implementation entirely or force compromises that dilute effectiveness.

Potential exists for a lack of funding to support implementation of regionalized approaches.

Operationalization of some regional strategies may be limited by lack of full alignment of goals and operational capacities of Collaborative members and/or existing state laws and regulations.

The region was devastated by Hurricane Helene in September 2024 and has been operating in a post-natural disaster environment. Collaborative members, who are public health leaders in rural communities, have been on the front lines of disaster response and recovery, which has delayed some activities. Despite these challenges, Collaborative members have remained engaged throughout the process.

Gaps exist in what public health is required to enforce and the impact of that enforcement (for example, fines for animal control violations are paid but problems don't get fixed).

Other context

A 2025 analysis conducted by the North Carolina Institute for Public Health explored current local public health capacity to deliver on the Foundational Public Health Services. It found that, in Region 1, LHD staff say that the Foundational Capabilities that are "covered well" in terms of local expertise are **Equity; Assessment & Surveillance; Policy Development & Support;** and **Emergency Preparedness and Response.** The Capabilities least well covered in terms of expertise are **Accountability & Performance Management; Communications;** and **Organizational Administrative Competencies** (Figure 2).

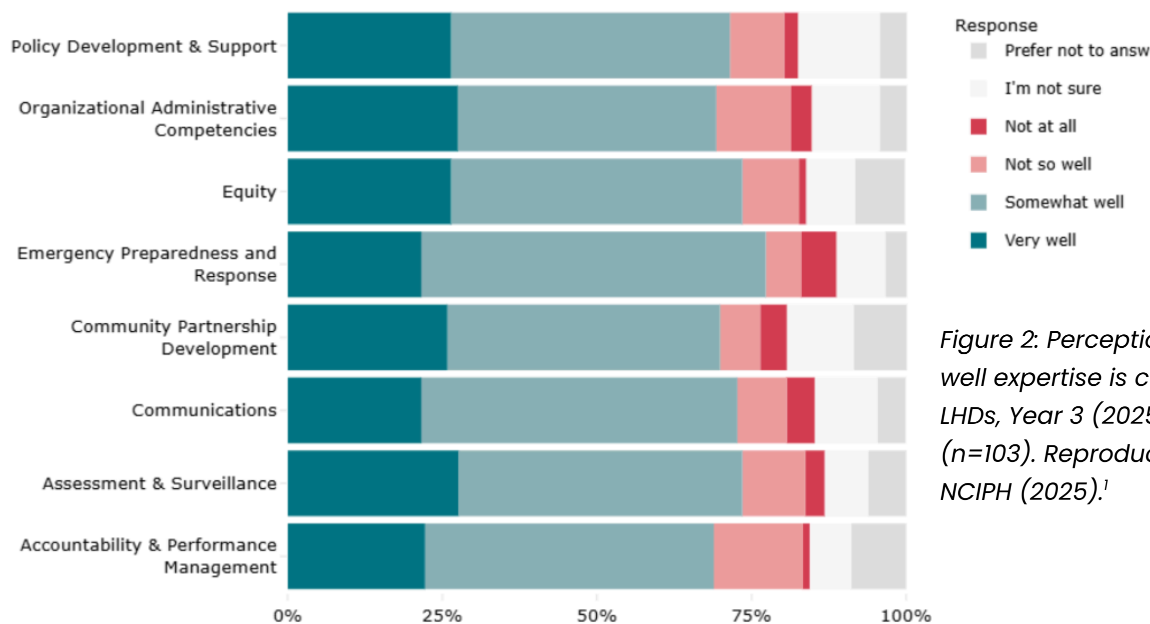


Figure 2: Perceptions of how well expertise is covered in LHDs, Year 3 (2025), Region 1 (n=103). Reproduced from NCIPH (2025).[1]

Region 1 LHD staff identified several key improvements in foundational public health capabilities over the past year, including:

Communications: significant progress has occurred with the addition of dedicated public health officers, improved crisis protocols, and better messaging strategies, though further development is still needed in social media and outreach methods.

Stronger **community partnerships** have emerged, particularly with emergency services and local organizations, which enhances visibility and collaboration.

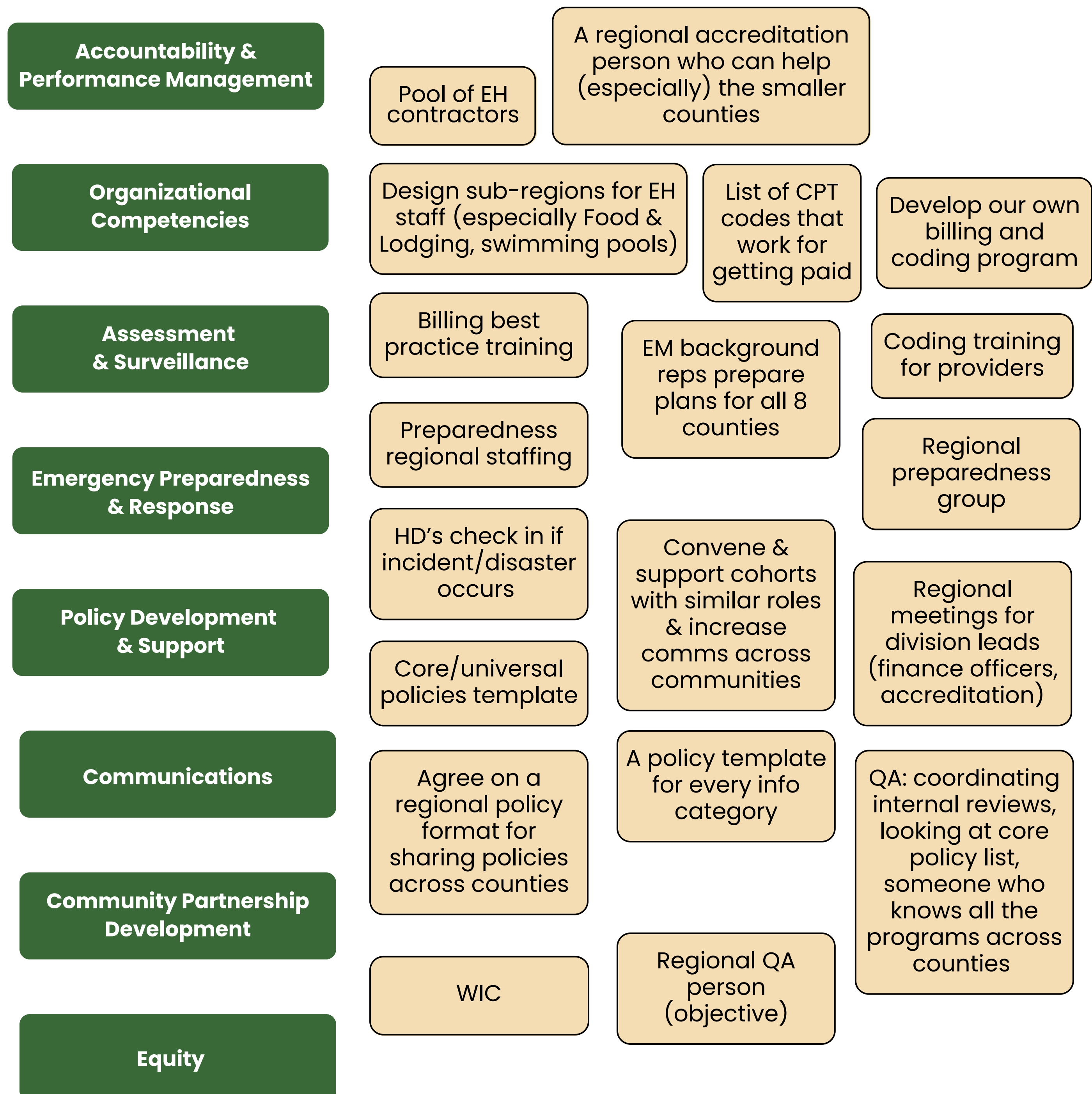
Workforce capacity has been strengthened through cross-training and support from new state-level pre-employment training initiatives.

Supportive and responsive leadership helps improve performance and morale.

Efforts to advance **equity** and local relevance in outreach were noted, including a desire for more localized communication tools.[1]

Strategies considered for *prioritization*

The Health Directors considered a wide range of strategies for regional collaboration.



Strategies

The Collaborative used the criteria below to select four strategies to focus on first, chosen from among the options on the previous page. These prioritized strategies are described on the following pages. Detailed implementation plans for each strategy are described in the accompanying Business Plan.

The Collaborative selected strategies that...

- Are best addressed regionally, rather than county by county
- Have potential for meaningful progress
- Are within the Collaborative's sphere of influence (are feasible)

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Regional Peer Networks

Why does this matter?

Health Directors identified specific areas (such as clinical billing & coding, and quality assurance) in which some Region 1 counties have more expertise and experienced staff than others. They see opportunities and a need to connect peer staff across counties to learn from each other, share best practices, surface ideas for what could work across the region, and feel supported by colleagues around specific aspects of their work. LHD staff also said that regional connections to peers in other counties would support their work.

> *“I feel supported and have a good network of Public Health professionals that I can reach out to if needed. Being a part of listservs, or committees help build those relationships across the State.” ~ LHD Staff*
>
> *“We should have a regional gathering/meeting...to introduce the teams and allow time for people to network with their cohorts.” ~ LHD Staff*

Staff have identified a number of areas in which they would like to (or need to) grow their skills and knowledge, including: billing & coding; quality assurance/quality improvement; finance & budget; crisis communications; conflict resolution; and IT/computer skills.

Who will be better off and how?

Frontline staff will be *connected* to, and know the peers they can call in other counties to talk through shared challenges.

Patients and the community will experience *improved quality* of services provided by staff.

Local health agencies will experience greater *financial stability* as expertise about reimbursement is shared among billing & coding staff across counties.

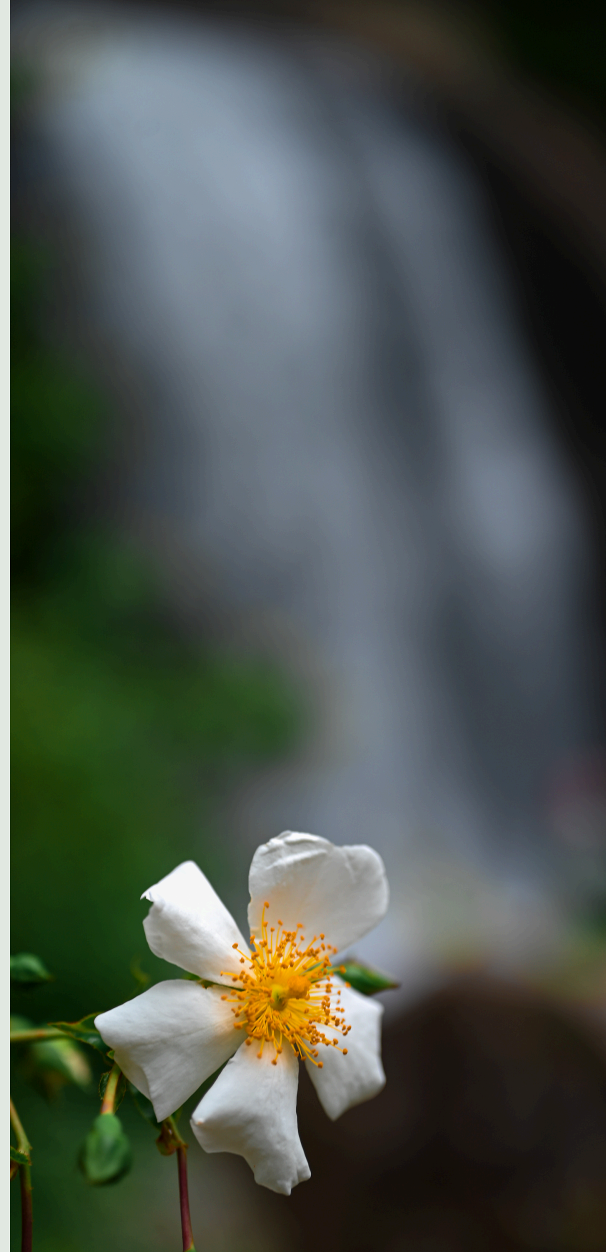
What will we need to keep in mind?

Things that might need to be overcome or addressed during implementation:

- Peer-led models are subject to "life getting in the way."
- Staff may want to prioritize their day-to-day role and may not want to add another meeting.
- Responsibility for maintaining the momentum for the group would need to be clarified.

Things that are true or in place that will support implementation:

- Existing regional peer networks already exist and offer models, including the Region 1 Health Directors themselves, Finance Officers, and Community Health staff.
- Other main sections also offer models, such as Clinical, Environmental Health Specialists, Health Educators, and Preparedness Coordinators.
- For some existing groups, an outside entity helps keep things on track (for example, WNC Healthy Impact for Health Educators).



KEY ACTIONS

→ Identify existing cross-county staff networks/groups. This will include gathering information like the groups' structure, meeting schedule (if applicable) and contacts.

→ Connect with these existing groups to understand what is already happening, and what gaps and needs exist.

→ Ask staff who do not already have a regional group/network (beginning with billing & coding staff) what value such a group might offer for their roles, and what that group would ideally look like.

→ Create regional directories of staff in various roles so peers in other counties can contact each other.

→ Discern what new group(s) to pilot, if any. Collaborate with staff to clarify goals and value for these groups, how those groups would ideally be structured and supported, and how the Health Directors would support these groups.

Regional Emergency Preparedness Staffing

Why does this matter?

LHDs are required to perform specific preparedness-related activities to fulfill their preparedness Agreement Addendum.

Currently, funds available through the state are insufficient to cover the local Preparedness Coordinator position that is necessary to accomplish these activities. Most counties in the region currently fund a Preparedness Coordinator position at 0.25-0.5 FTE.

Health Directors and LHD staff see opportunities to shift at least some preparedness activities to a regional position. These include developing and maintaining local preparedness plans (which are template-based), supporting a regional preparedness group, and coordinating preparedness training (such as Incident Command System training) across the region, which would help all counties meet requirements.

Piloting a regional preparedness staff position can serve as a testing ground for future regional staffing models. Lessons learned can inform broader roll-out and can build confidence in regional collaboration.

Who will be better off and how?

LHDs will have more *sustainably-funded* preparedness positions and programs.

Local Preparedness Coordinators *will feel supported* and have a workload that is more commensurate with their FTE.

Communities across the region *will be served* by a trained and coordinated regional public health preparedness workforce.

What will we need to keep in mind?

Things that might need to be overcome or addressed during implementation:

- Not every county has a full-time dedicated Preparedness Coordinator position to fulfill requirements of the state.
- In certain counties, other county staff (e.g., tax admin) need to get Incident Command System training.
- Preparedness plans sit on a shelf in most situations.
- Break down happens between local and state emergency management efforts, and it takes too long to wait for the state when an event happens.
- There is a need to bridge gaps between public health preparedness requirements and emergency management.

Things that are true or in place that will support implementation:

- Other existing efforts to support emergency preparedness capacity include: The North Carolina Institute of Public Health received funding to be the southeast training hub for preparedness; regional monthly preparedness meetings; existing preparedness trainings; Emergency Management Collaboration; and Western Carolina University's program to train people to be preparedness coordinators.
- Region 1 counties have recent experience implementing preparedness and emergency management functions (for example, Tropical Storms Fred in Haywood County, and Helene in multiple counties).
- Some counties have effective Public Information Officers who get information out for all the local agencies during a crisis.
- Overall, the state emergency management system functions well (although public health integration into that system could be better, and it's challenging to figure out public health's role in the system).

KEY ACTIONS

→ Note: Health Directors have already crosswalked existing resources and capacity (in staff FTEs) by county related to preparedness.

→ Understand the legal and administrative implications of the range of options for establishing a regional position shared by eight counties (for example, establishing a 501(c)3 or hiring through the North Carolina Alliance of Public Health Agencies), and choose a structure.

→ Establish administrative mechanisms and structure to support the position (including funding allocations and formal contracts between counties, job description, hiring and supervision structure, and formal contracts).

Regional WIC Staffing

Why does this matter?

All eight counties in Region 1 offer services through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Some counties have a hard time retaining certain WIC positions, particularly WIC Directors. Current WIC funding does not fully cover program expenses and staffing costs. Health Directors and LHD staff see opportunities and advantages to sharing WIC staff capacity across counties, including leveraging economies of scale for specific WIC activities and providing remote WIC services during staffing shortages. Establishing a regional WIC staffing model would improve program coverage and efficiency.

Who will be better off and how?

People receiving WIC services in Region 1 will have more *consistent access* to these services, including in shifting situations such as natural disasters.

WIC staff will receive *more meaningful pay.*

LHDs will be able to offer more *reliably-staffed, financially sustainable* WIC services.

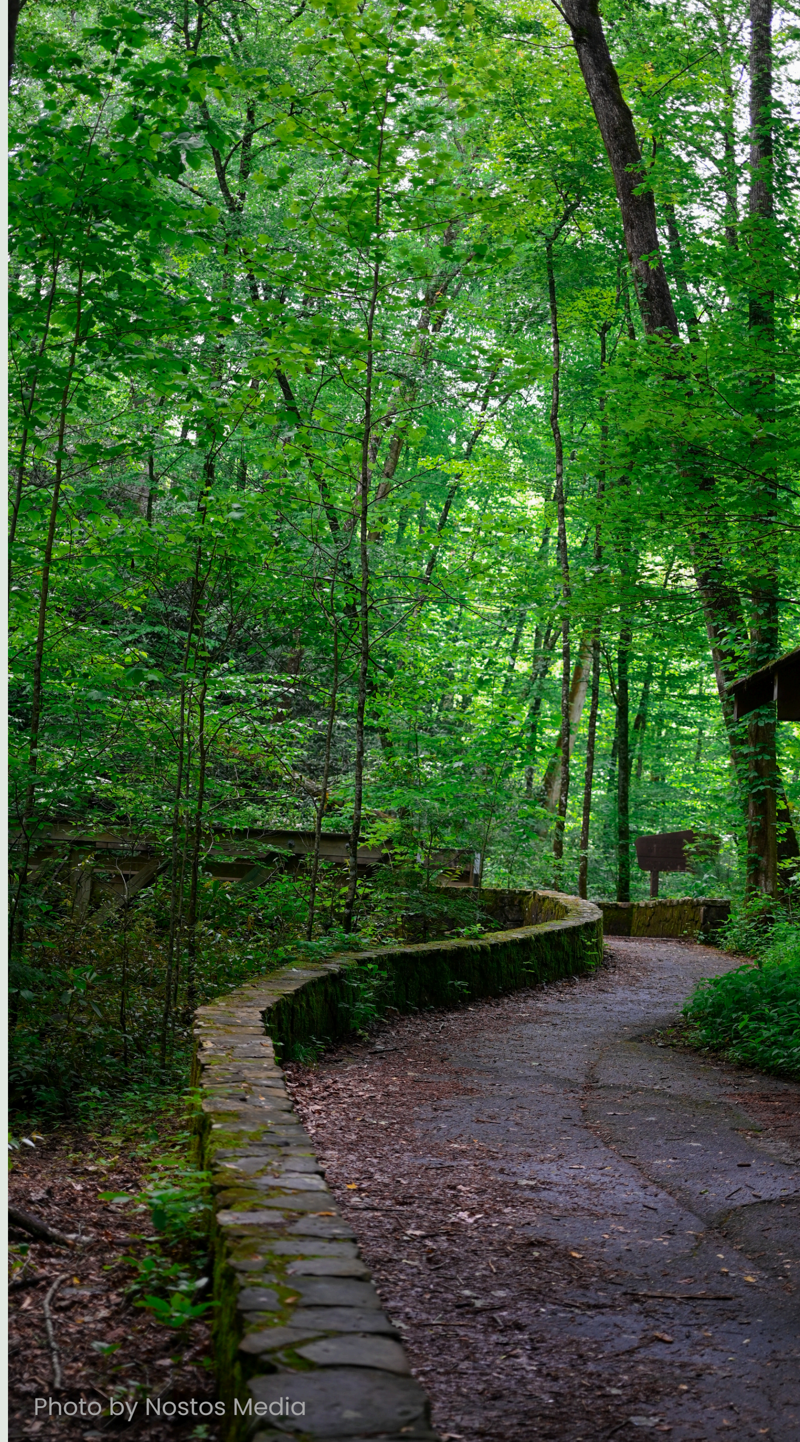
What will we need to keep in mind?

Things that might need to be overcome or addressed during implementation:

- The state may push back on shifting Region 1 to a regional staffing model.
- It will continue to be necessary to maintain compliance with WIC policies and frequent audit cycles.
- County leadership approval will be necessary.

Things that are true or in place that will support implementation:

- Precedent exists within North Carolina for regionalizing public health nutrition program service delivery.
- Experienced WIC staff from certain counties in Region 1 can contribute knowledge and experience.
- Lab staff may be able to assist for certain labs, such as hemoglobin. Medical offices may also be able to scan and send labs.
- A window of opportunity exists to "pitch" a regional model to county leadership.



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KEY ACTIONS

→ Identify which counties would participate in a regional WIC staffing model.

→ Develop a viable funding model (based on population or service need) that demonstrates improved efficiency and compliance, and pitch the model to county managers to gain buy-in.

→ Leverage learning from the regional preparedness position research to inform cross-county agreements/contracts, position descriptions, and salary structures.

Shared Policy Development

Why does this matter?

LHDs in the region have, over time, amassed a large set of agency policies covering every area from lab to epidemiology to finance to privacy. In many cases, these policies have been inherited from previous leaders and staff. Staff have not received adequate training to write a policy and tend to defer to guidance from various state consultants. Over time, this piecemeal approach–which attempts to meet compliance and auditing requirements–results in convoluted and confusing policies (which are often technically a mix of policies and procedures). All of this makes it challenging for staff to access and understand how to interpret the policies, reducing the likelihood they are being followed as designed and increasing the risk of non-compliance or legal consequences for the LHDs themselves. Developing a standardized set of vetted, core policies that can be used across counties will help address these challenges.

Who will be better off and how?

LHDs will have a set of *core policies* that are legally sound and pass compliance scrutiny.

LHD staff will know how to access their agency's policies and understand what they mean and how to *follow them.*

Clients will be served by programs and services that are governed by clear policies ensuring *privacy, safety and quality.*

What will we need to keep in mind?

Things that might need to be overcome or addressed during implementation:

- Hiring skilled legal counsel to support policy review and revision is expensive.
- A comprehensive review of agency policies is very time consuming, and there is not currently confirmation from the state that the revised policies will comply with current state requirements.
- Staff time will need to be allocated for their input and review of policies.

Things that are true or in place that will support implementation:

- An inventory of local policies across all eight counties has been developed as part of the Gaps & Opportunities Assessment.
- Two Region 1 counties have engaged an experienced attorney to review and revise their local policies. These processes can act as a model or pilot for the other counties.
- The attorney is willing to support the entire region in policy review and revision, as well as train staff on policies.
- Developing policies with collaborative input from staff builds buy-in and ensures policies are followed.

Photo by Nostos Media

KEY ACTIONS

→ Engage the experienced attorney to develop a policy template and guide the Collaborative to identify ideal policy formats.

→ Identify a set of core policies that overlap in all eight counties and pilot developing standard policies for one department (likely Laboratory).

→ Create a structured process for group editing and approval of policy templates (which can then be taken back to staff to modify based on local needs).

What's *next?*

The Collaborative will pursue implementation of these regional priorities as articulated in the Business Plan, and through continued alignment with other regional, statewide, and national efforts. It will also seek to leverage diversified funding streams for these objectives. Lessons learned from implementation of these priority strategies will inform future efforts to strategically regionalize efforts and activities.

Photo by Nostos Media

References

[1]North Carolina Institute for Public Health. (2025). *NC Foundational Capabilities Opportunities Analysis: Phase 4 (2025) – Region 1 Preliminary Results.*

[2]North Carolina Public Health Region 1. *Public Health Workforce Development Plan: North Carolina Public Health Region 1.* Published 2023.

[3]Public Health Accreditation Board. The Foundational Public Health Services. Available at: https://phaboard.org/center-for-innovation/public-health-frameworks/the-foundational-public-health-services/. Accessed June 30, 2025.

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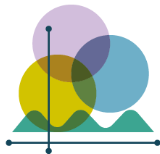

WNC HEALTH NETWORK

Macon County
Public Health