CHAMPAIGN COUNTY BOARD OF HEALTH

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Champaign County Board of Health

Tuesday, November 27, 2007
6:00 p.m.
Brookens Administrative Center, 1776 E. Washington
Meeting Room 3
Urbana, Illinois
PLEASE NOTED THE CHANGE IN ROOM LOCATION

AGENDA

ITEM		PAGE NO.
A.	**Call to Order**	
B.	**Roll Call**	
C.	**Approval of Agenda/Addendum**	
D.	**Approval of Minutes** – October 30, 2007	1-10
E.	**Public Participation**	
F.	**Mental Health Board** *(Please Bring Emailed Attachments to the Meeting)* 1. Status of Joint Funding with the Mental Health Board & Consideration of Possible Program Directions 2. Information Regarding the Process and Procedures Used by the Mental Health Board to Evaluate Grant Requests	
G.	**Monthly Reports** 1. CUPHD Monthly Reports – October 2007 2. CIDES Report – October 2007 *(To Be Distributed)*	
H.	**Correspondence and Communications**	
I.	**Treasurer's Report**	
J.	**Finance** 1. Development of Format for Objectives and Indicators for the Next Budget Cycle	

2. Ideas Regarding One-Time Infusion of Funding from IDPH

K. Issues Regarding CUPHD

1. Report from Acting CUPHD Administrator
2. Creation of a Subcommittee to Consider Possible Merger Between Board of Health and CUPHD

L. Other Business

1. Approval of Regional Emergency Coordination Intergovernmental Agreement	11-21
2. Renewal of CIDES Contract	22-30
3. Approval of 2008 Calendar of Meetings	31

M. Adjournment

CHAMPAIGN COUNTY BOARD OF HEALTH

Monthly Meeting
Tuesday, October 30, 2007

Call to Order

The Board of Health held its regular monthly meeting on October 30, 2007 in Meeting Room 2 at the Brookens Administrative Center, 1776 East Washington, Urbana. The meeting was called to order at 6:00 a.m. by Julian Rappaport.

Roll Call

Susan Maurer called the roll. Board members present at the time of roll call were Stan James, Susan Maurer, Tom O'Rourke, Julian Rappaport, Betty Segal, and Carrie Storrs. John Peterson arrived later. Absent Board members were Nezar Kassem and Prashanth Gowda. Staff present were Kat Bork (Board of Health Secretary) and Susan McGrath (State's Attorney's Office. Others present were Nancy Greenwalt (CIDES Executive Director), Jill Meyers (CIDES), C. Pius Weibel (County Board Chair and CUPHD Board Member)

Approval of Agenda/Addendum

MOTION by James to approve the agenda; seconded by Storrs. **Motion carried.**

Approval of Minutes

MOTION by James to approve the Board of Health September 25, 2007 minutes; seconded by O'Rourke. **Motion carried.**

Peterson entered the meeting at 6:03 p.m.

Public Participation

Weibel stated that he wanted to be able to leave the meeting as quickly as possible and requested any business that he could assist with be moved to the top of the agenda. The Board agreed to deal with agenda items J 3 through 5 first. Greenwalt and Meyers indicated they were present for the CIDES issues. Rappaport agreed to allow them the opportunity to speak when the Board reached those agenda items.

Anika Atbasi, a pre-dental student at the University of Illinois, urged the Board of Health to approve the additional funding requested by CIDES for the children's program and to consider providing for a dental program for adults.

Monthly Reports

MOTION by James to receive and place on file the CUPHD September 2007 monthly reports, the CIDES September 2007 monthly report, and the CIDES financial statements for 2005 and 2006; seconded by Maurer. **Motion carried.**

Correspondence and Communications

Rappaport provided the letter that he sent to Weibel and the other CUPHD Board members regarding the Breast & Cervical Cancer Program. Weibel stated he would bring up the concerns raised in the letter at the CUPHD Board meeting scheduled for the next day.

Treasurer's Report

Invoices submitted by CUPHD for August 2007 and September 2007

Peterson reported that the Board of Health looks to be on target for the budget levels.

MOTION by Peterson to approve the invoices submitted by CUPHD for August 2007 and September 2007; seconded by Maurer.

Rappaport asked about the payments CUPHD is invoicing the Board of Health for home nursing, which is a program that no longer exists. Peterson said it is money down the drain. The Board of Health committed to paying for it until the end of the fiscal year on November 30, 2007.

Board of Health FY2007 Budget Projection Report from County Administrator of Finance

This agenda item was withdrawn.

Finance

Reconsideration of CIDES Appropriation in FY2008

The Board began with the request for funding the children's dental program. Rappaport described the study session where the Board considered the CIDES request for an increased funding level for the Children's Dental Access Program in FY2008 on some detail. CIDES is requesting over $130,360. The Board had been appropriating $105,000 for CIDES annually. The Board has budgeted $105,000 in its FY2008 budget for CIDES. The Board approved increasing the FY2007 with a one-time appropriation of $15,000 at the last meeting. CIDES's request for FY2008 is even larger. Rappaport said he would recognize Board members equally with pro and con opinions.

MOTION by Segal to approve an increased FY2008 appropriation of $130,000 for the Children's Dental Access Program; seconded by Maurer.

James stated that he did not know if he will oppose the appropriation, as he was not at the study session. He asked if CIDES is hoping to reach out to Lincoln's Challenge in Rantoul. Greenwalt said yes. James had a problem with that idea because most of Lincoln's Challenge's clients come from other communities and other counties. Lincoln's Challenge might also be scaling back because of funding cuts. James wanted to include in the CIDES contract language that if Lincoln's Challenge does shut down then the money will be returned to the Board of Health and not spent elsewhere. He was concerned about the Board being locked into an agreement to pay money even when the program does not work out, like it is with the now

defunct home nursing program. He stressed there has to be accountability and guidelines. James thinks there is a need in the elderly population for services, which is a population not as vocal about their needs as others. Greenwalt confirmed CIDES will be expanding to Lincoln's Challenge and promised no County money will be spent on Lincoln's Challenge. She explained the mobile clinics going to schools have tremendous Medicaid reimbursement, so there is no County money used when CIDES goes to most of the schools. Provena has donated $2,500 for the first restorative care days. She hopes the increased $25,000 from the Board of Health will provide for uninsured kids in the mobile clinics at grade schools and private dentists' offices. McGrath said the CIDES contract is up for renewal so they can incorporate language about what the County money can be spent on. Rappaport directed, with the Board's consent, that the language about County money not being used for Lincoln's Challenge be included in the CIDES contract and brought to the Board at the next meeting for approval.

O'Rourke said he would not vote for the increased funding. He supports funding at the same amount that CIDES received last year, but said the Board needs to have a discussion concerning the other unmet health needs in Champaign County. The Board needs to have a process set up to evaluate funding requests. O'Rourke stated he was not opposed to CIDES as a program, he would simply vote against increases for any program until an evaluation process is in place. His concern was that there are loads of other people who do great things in the community who have not been considered by the Board for funding. O'Rourke's objection is this is not good policy. Rappaport noted the point is well taken and setting up such a process will be discussed later on the agenda.

Segal stated this is not the time to set up a process for funding in FY2008. Peterson and O'Rourke pointed out that the Board has a contingency fund in FY2008 so the Board can take the time to develop an evaluation process before spending any of the contingency fund. O'Rourke would support funding CIDES at $105,000 again in FY2008 and then consider their request for more money after a process is developed. Segal supported the additional funding because dental services for kids are needed in the County and she felt it is an under-funded area.

Peterson raised the issue of Medicaid funding, namely that every one of the children served by CIDES is covered by Medicaid, yet because local dentists will not accept Medicaid as a form of payment, the County is using local tax dollars to pay for services that have complete Medicaid coverage. Peterson reiterated some of his statements from the study session; specifically that France Nelson could have a program that would get the Board more bang for the buck because that entity gets more Medicaid reimbursement. His opposition to expansion of the CIDES program is that CIDES has no design to take advantage of the fact that they are serving children on Medicaid. If the possible Medicaid reimbursement was fully realized, then CIDES could expand their program or request less of a subsidy from the Board of Health. In terms of economics, the current model is not the best model.

Storrs said it has been established that oral health is one of the highest priority needs in the County. She felt, in the absence of access to dental providers for Medicaid clients, it is not inappropriate for the Board to continue to fund services for the next fiscal year, as well as exploring other avenues. Storrs said, as a board of public health, we should work towards the objective of improvements in oral health in Champaign County.

James wondered if giving more money would solve the problem if the main problem is with getting dentists to do the work. Storrs asked if Greenwalt is seeing more cooperation with the dentists. Greenwalt stated that dentists in East Central Illinois do not take Medicaid. The dentists are willing to work with CIDES because they bill CIDES for half of their costs and donate the other half. The reimbursement rate from CIDES is more than what the dentists would receive from Medicaid. Two local dentists will let CIDES recoup money from Medicaid for the clients the see. Discussion continued over the CIDES request for funding children's services.

McGrath inquired whether the Board wanted to insert language in the next CIDES contract that designates the additional funds as a one-time grant, not an annual increase that will continue each year. Rappaport had suggested that approach about the adult program proposal that was presented at the study session. Rappaport said CIDES has been a good program and the Board has gotten reports that make him feel comfortable with the money that CIDES has been given. Given that the increased funding would all go to providing more services, he felt the increase represented a good purchase. He said CIDES has earned his solid support for funding children's dental services. A roll call vote was ordered.

Motion carried with a vote of 5 to 2. Maurer, Peterson, Rappaport, Segal, and Storrs voted in favor of the motion. James and O'Rourke voted against the motion.

The Board moved on to consideration of the application for the creation and funding of an adult dental program.

MOTION by Storrs to approve $50,000 to fund an adult dental program through CIDES; seconded by Segal.

Peterson began by stating he is against the program as it is currently presented. The adult program would give the Board of Health a lot less bang for the buck in terms of design. He said any adult program should have Frances Nelson involved. Peterson was concerned about using the entire contingency fund for additional dental funding. He reminded the Board that they are implementing two entirely new programs in FY2008, the mobile unit with CUPHD and the senior services program with the Regional Planning Commission. As Treasurer, he projected that both programs would likely cost more next year, so if the Board funds the adult dental program they will have to significantly spend their carryover. Peterson estimated that the senior services program will ask for $80,000 in the next fiscal year. He thinks RPC will do well with the program and need more money in continuing years, so he is timid on more dental spending. He would like to see a better model for an adult dental program before eating into the Board of Health's carryover.

Storrs spoke about the importance of oral health and the impact on communities. She wondered if there was a way the adult program could focus only on primary or secondary preventative services. She asked about CUPHD's capacity. Peterson explained that CUPHD had informed the Board that they have a dental team, but they are working hard just to meet the demand for services in Champaign-Urbana. CUPHD did not submit a proposal to the Board of Health to provide dental service because they felt unable to serve more than the Champaign-Urbana residents at their current capacity. Storrs said she was under the impression that CUPHD

applied for a grant that required them to accept dental clients from outside the cities. Greenwalt said the joint grant proposal with CUPHD, CIDES, and Frances Nelson was not funded.

The Board continued to discuss the adult program proposal without reaching a consensus. Rappaport suggested the Board first develop a procedure to evaluate proposals from all entities and ask CIDES to submit their adult program proposal then. James concurred with Rappaport's idea to wait. He understood that there is a need for these services and spoke about programs that exist through other organizations. James recommended ensuring the Board of Health money is going where it can go the farthest. He noted a lot of County residents are worried about rural residents because they see their tax dollars going to Champaign-Urbana residents. He applauds the work CIDES does, but would prefer the Board set up a process to consider funding first. He does not want the Board to spend money just because they have it and urged more conservation.

Storrs and Segal agreed to withdraw the motion.

Establishment of Process for Entities to Make Requests to the Board of Health

McGrath suggested having some thoughts about what the process would be. Rappaport asked for volunteers to form a subcommittee to develop the process by which entities would make requests to the Board of Health. James suggested including this as a future agenda item and contacting Peter Tracy of the Mental Health Board because he has done a wonderful job developing the criteria to evaluate the County Board's Quarter Cent for Public Safety Juvenile Delinquency Grant applicants. This criteria is used to select the winning applicants for the grants and the Mental Health Board staff also monitors the grant recipients throughout the year to track whether the stated goals are being met. Rappaport offered to communicate with Tracy for his expertise on this type of issue. The Board concurred with placing this item on the November agenda and having Rappaport contact Tracy.

Creation of a Subcommittee to Develop Objectives and Indicators for Next the Budget Cycle

Maurer stated that she requested this item be placed on the agenda because the budget document that is submitted to the County Board requires budget objectives and indicators. This is something the Board of Health needs to develop. Maurer volunteered to put together a format and share it with other Board members to get their feedback as a starting point. Segal offered to help. The Board agreed a subcommittee should not be organized since Maurer and Segal will work on the format together. McGrath cautioned the Board that any more than 2 members of a 9-member board meeting together to discuss business is a violation of the Open Meetings Act.

Recommendations Regarding One-Time Infusion of Funding from IDPH

Rappaport requested an update on the status of this money. McGrath indicated that Julie Pryde told her the $52,000 from IDPH has been received and needs to be spent by June 30, 2008. Rappaport suggested the Board could consider how to use the IDPH money by evaluating funding requests that are received and examined through the evaluation process, once it is developed. While it is recommended that the one-time fusion of funding be spent on a one-time

expense, such as a capital improvement project, it does not have to be used this way. Storrs relayed another recommendation from Pryde on what the Board could spend its money on: purchasing electronic defibulators for CUPHD's mobile units and the Rantoul site. Rappaport said the Board is free to spend the money on whatever it wants because there are no restrictions from IDPH and suggested waiting to decide how to spend the money. Maurer noted it could be spent on equipment or on services. James said the Board could buy equipment, such as defibulators, and donate them to rural fire departments. Rappaport and O'Rourke agreed with that type of idea. Rappaport directed that this item be placed on a future agenda and for Board members to come back with any ideas for the use of funds.

Issues Regarding CUPHD

Approval of Mobile Unit Service Plan

The proposal for mobile programming in Champaign County from Julie Pryde was distributed to the Board via email prior to the meeting. Maurer pointed out that Pryde's proposal was $5,000 more than the original budget. McGrath said the additional $5,000 was ads and marketing.

MOTION by James to approve the mobile program in Champaign County as presented by CUPHD; seconded by Peterson. Peterson said he was seconding the original budget. Storrs requested a friendly amendment setting the budget for the mobile program at the original budgeted amount $77,232 amount for FY2008. James and Peterson agreed to consider the amendment as friendly.

The Board discussed the proposal from CUPHD and the fact that it did not match the amount that was budgeted for the program. Rappaport declared a 5-minutes recess at 7:30 p.m. in order for Bork to retrieve the Board of Health's FY2008 budget to confirm the mobile program budget. It was confirmed that the Board approved $77,232 in their FY2008 budget for the mobile program.

James withdrew his motion.

MOTION by James to approve the mobile program in Champaign County without exceeding the original budget of $77,232; seconded by Peterson.

Storrs recommended cutting some services expenses in order to do some marketing. James thought Pryde's plan was to park the mobile units at certain places in communities at certain times, then have the community centers, etc. pass the word around when the mobile unit would be available to residents. He felt word of mouth could spread knowledge of the services. Storrs pointed out the proposal suggests parking the mobile unit at trailer parks, but the Board should give some thought to marketing. Marketing can be done for a cost lower than $5,000, for example putting flyers in mailboxes at trailer parks. James understood that Pryde was going to contact local community leaders some their ideas on the best times and locations to park a mobile unit and to get the word out. McGrath verbalized that radio and newspaper ads are not the most effective advertising unless one plans to saturate the market. The Board discussed various ideas to advertise the mobile unit's existence and schedule, such as public service

announcements, letters to the editor in the *Rantoul Press*, and contacting schools to send information home with the students. James said he would contact Pryde to talk with her about distributing flyers at Rantoul laundry mats and grocery stores. The Board discussed the schedule put forth by Pryde. James noted the mobile unit program is new and some ironing out of details will occur. Pryde had indicated at a previous meeting that she would be willing to make any changes requested by the Board. When Segal requested the mobile unit provide services after 5:00 p.m. McGrath reminded the Board that the IRS is very picky about independent contract services, so Board cannot direct CUPHD staff manning the mobile unit to work beyond their normal working hours for both tax and liability reasons. Storrs added that once the indicators and objectives are in place for this program the Board will be able to tell if the program is meeting its goals.

O'Rourke exited the meeting at 7:49 p.m.

Rappaport said he was not pleased with the evaluation tools. Segal asked about services for the many overweight County residents. The Board continued to discuss the various service options presented with the mobile unit.

O'Rourke re-entered the meeting at 7:51 p.m.

Maurer suggested the Tamie Nagrodski come to the Board meetings to give detailed reports on the mobile unit program. James said it was important not to micromanage how the staff does their jobs. Rappaport would like to see hard information on the mobile unit outcomes. If the Board has outcomes information, they can see if progress is being made. O'Rourke suggested CUPHD supply basic information, including number of people seen, cases identified, and referrals made. The Board concurred that it wanted Tamie Nagrodski to attend future meetings to have interaction with the Board about the mobile unit.

Peterson reported that the Village of Philo formally objected to not being included even after the village specifically said they did not want services. Peterson will make a point of this to CUPHD next month. The Board understood that the mobile unit program is flexible and the services can be changed.

Report from Acting CUPHD Administrator

Information from the Acting CUPHD Administrator was provided via email.

Report from Contract Subcommittee

O'Rourke reported that the Contract Subcommittee met with Pryde to take her take on the drafted revisions to the contract with CUPHD. The subcommittee desired to see if Pryde had any problems to the contract as the CUPHD Administrator and whether she had any suggestions. O'Rourke stated Pryde was very helpful at the meeting. She indicated two items of concern that the subcommittee found valid and agreed with her assessment. One issue was to change Item 10 on the contract to reflect that the Board of Health shall approve the application for any new grants, since many of the grant applications are simply requests to renew present grants. The

contract language was changed to reflect Pryde's recommendation. The second issue regarded the Board of Health request to be involved in the evaluation of the CUPHD Administrator. Pryde suggested the Board of Health provide an evaluation of the Administrator to the CUPHD Board to be a piece of the total evaluation. The subcommittee concurred with the idea of completing a peer review of the CUPHD Administrator and assisting the CUPHD in the evaluation of the Administrator in any other manner agreed upon by the Board of Health and CUPHD. The Contract Subcommittee wanted the Board of Health to be one component of the evaluation with the understanding that the CUPHD Board is the ultimate decision maker. They just wanted to be a part of the evaluation process. Pryde had no objection to those points. The subcommittee would like for Rappaport to contact Carol Elliott of the CUPHD Board in order to set up an initial discussion about the contract process. Then the Contract Subcommittee would like to meet with whomever the CUPHD Board designates to discuss the contract revisions.

Rappaport recommended holding a joint study session between the two boards to discuss the contract, not to approve it. The Board of Health was willing to meet with anyone CUPHD would like to attend. Rappaport suggested it be a meeting without the lawyers in order for the participants to discuss their intentions. McGrath concurred. Rappaport asked if this procedure made sense to Weibel. Weibel answered positively, but added that Elliott might want the CUPHD lawyer to attend the meeting. The Board agreed that Rappaport should contact Elliott.

Approval of Revised CUPHD Contract for Discussion with the CUPHD Board

MOTION by O'Rourke to approve the revised CUPHD contract as a draft for discussion to forward to the CUPHD Board; seconded by Storrs. **Motion carried.**

Creation of a Subcommittee to Consider Possible Merger Between Board of Health and CUPHD

Rappaport explained that this item emerged from a discussion at the Policy, Personnel, & Appointments Committee meeting of the County Board. At that meeting, McGrath was directed to research the legal issues involved in a merger of the two public health entities and report back to the committee, possibly in January. Rappaport attended the meeting and informed the Policy, Personnel, & Appointments Committee about the previous consultant's report that recommended a study of the financial and legal implications of such a merger, as well as investigating way the two boards could work together in the meantime. Rappaport suggested creating a subcommittee to explore this idea. The Board of Health discussed forming a subcommittee and who would comprise its membership.

MOTION by O'Rourke to create a subcommittee to consider a possible merger between the Board of Health and CUPHD; seconded by Peterson.

Storrs stated she is going to the Mid-America Public Leadership Institute, a year-long institute, on behalf of the Board. A part of institute will be a team assistance project and an individual assistance project. She inquired if the Board would like her to propose this to the Leadership Institute as a potential topic for a team assistance project. It could benefit other public health entities and enable the Board to get the benefit of expertise from other areas. The Board was very much in favor of Storrs presenting the topic to the Leadership Institute.

Rappaport asked for volunteers for the subcommittee. As President, he is an ex-officio member of every subcommittee. O'Rourke suggested contacting former CUPHD Directors, such as Dick Graber, and including non-board members on the subcommittee. McGrath suggested working at the Board level first to develop an action plan before getting public input. O'Rourke wanted to give it more thought before forming a subcommittee. Storrs was willing to be on the subcommittee. Other members were interested, but are already on other subcommittees. The Board agreed to ask Kassem and Gowda if they are interested before forming the subcommittee. O'Rourke asked for any Board members who attend an outside meeting on behalf of the Board to report back at the next Board meeting. The Board thanked Weibel for attending the meeting and he exited after thanking them for reordering the agenda.

Other Business

Report on Mental Health Board Meeting

Rappaport reported that he attended the Mental Health Board meeting to inform them that the Board of Health allocated money for the joint program, but he has not heard that MHB has also allocated their share of the money. Rappaport will speak to Peter Tracy about this matter.

O'Rourke exited the meeting at 8:06 p.m.

Possible Revisions to Public Health Ordinance

McGrath spoke to Jim Roberts at CUPHD about the draft ordinance. Roberts will be getting back to McGrath and then she and Storrs will proceed with the environmental aspects of the ordinance. Storrs had a lead from the Leadership Institute that the State of Indiana has a template from which a public health department can build a public health ordinance. McGrath has talked about this with John Dwyer at CUPHD. It would take a change in state legislature for Illinois to guarantee a template. Rappaport asked when the ordinance would be brought to the full Board. McGrath recommended placing it on the January agenda.

Board of Health Website

Segal expressed her opinion that the Board of Health website posted by CUPHD is abysmal and very outdated. CUPHD maintained the website and the previous administration refused to update the site last year. Bork explained the Board of Health has a web page maintained by Champaign County Administrative Services. This page has posted all the agendas, approved minutes, and contact information for the Board. Any additional materials can be added as the Board sees fit. McGrath noted the Board does not own the domain name to the CUPHD site. Storrs recalled that Pryde recommended the Board of Health create a logo like CUPHD's. James suggested that it is not worth it to spend money on website development if the two public health entities may be moving towards a merger. The Board agreed that it wanted some sort of signage that would identify that the mobile unit was being provided to residents by the County Board of Health. The Board discussed creating a logo that would symbolize the County Board of Health. Storrs recommended adding the words "Serving Champaign County" to the mobile unit itself and any flyers advertising it. The Board agreed that the mobile unit should have some form of notice that it is provided by the County. The Board directed Bork to

contact CUPHD IT staff person to shut down the CUPHD-managed Board of Health website. The Board of Health further directed that the link on the County-maintained web page be changed to direct people to CUPHD's main website. Segal suggested that Rappaport write letters to editors of local newspapers to announce the mobile unit.

Establishment of Date or Cancellation of November Board Meeting

The Board confirmed the date of the next meeting as November 27, 2007. There will be no meeting in December. McGrath stated she would not be able to attend the November meeting, but she promised to fully report to the Board well before the meeting.

Establishment of Study Session in November

The Board agreed that no study session was needed in November.

Adjournment

Meeting adjourned at 8:25 p.m.

Respectfully submitted,

Kat Bork
Board of Health Secretary

INTERGOVERNMENTAL AGREEMENT

REGIONAL EMERGENCY COORDINATION
CHAMPAIGN COUNTY, ILLINOIS

WHEREAS, the Constitution of the State of Illinois, 1970, Article VII, Section 10, authorizes intergovernmental cooperation in any manner not prohibited by law or by ordinance; and

WHEREAS, the Intergovernmental Cooperation Act, 5 ILCS 220/1, et seq., provides that any power or powers, privileges, functions, or authority exercised by a public agency of the state may be exercised, combined, transferred, and enjoyed jointly with any other public agency of the state; and

WHEREAS, the Illinois Emergency Management Act, 20 ILCS 3305/13, authorizes mutual aid agreements and encourages mutual aid agreements; and

WHEREAS, Homeland Security Presidential Directive 5, "Management of Domestic Incidents" requires that local jurisdictions adopt the National Incident Management System (NIMS) to access federal preparedness funding; and

WHEREAS, the NIMS document and requirements provide for the creation of Multiagency Coordination Systems (MACS) with responsibility for supporting incident management policies and priorities, facilitating logistics support and resource tracking, informing resource allocation decisions using incident management priorities, coordinating incident related information, and coordinating interagency and intergovernmental issues regarding incident management policies, priorities, and strategies; and

WHEREAS, the State of Illinois NIMS Implementation Plan dated August 12, 2005, provides for the development of multiagency coordination entities; and

WHEREAS, mutual aid agreements addressing operational issues serve a vital part in responding to occurrences that impact multiple jurisdictions or that are beyond the ability of any one community to control.

NOW, THEREFORE, the Parties to the Agreement agree as follows:

SECTION I
Purpose and Commitment

1.1 The purpose of this Agreement is to involve policy-making officials of the Parties in a coordinated undertaking to identify important underlying policy issues and, to the extent practicable, develop unified policies that will facilitate coordinated operational responses when facing potential threats to public safety that traverse jurisdictional boundaries or exceed the ability of any one community to adequately respond given limited manpower, equipment or other resources.

1.2 The Parties to this Agreement agree, to the extent possible, to coordinate individual emergency plans in accord with this Agreement.

SECTION 2
Definitions

2.1 **Community Emergency Event**. A situation impacting the greater Champaign-Urbana community which has been declared an emergency by the President of the United States, the Governor of the State of Illinois, the Mayor of a party, the Chancellor of the University of Illinois, the Chair of the Champaign County Board, Director of the Champaign-Urbana Public Health District or the President of the Champaign County Board of Health.

2.2 **Emergency.** The imminent threat or actual occurrence of a disaster, civil emergency or utility emergency affecting the residents and inhabitants under the jurisdiction of the Parties.

2.3 **Emergency Operations Plan (EOP).** A written plan describing the organization, mission, and functions of the government and supporting services for responding to and recovering from emergencies, including provisions that account for the needs of individuals, household pets and service animals.

2.4 **Liaison.** A local public safety official designed by the Parties to serve as a liaison for the various operational units of the Parties.

2.5 **Operational Emergency Response personnel**. Police Chiefs, Sheriffs, Fire Chiefs, City and County Emergency Management Director, METCAD Director, Illinois Emergency Management Agency Regional Coordinator and University of Illinois Director of Emergency Planning and other party personnel that provide operational services during Community Emergency Events.

2.6 **Original Parties**. Champaign County, The City of Champaign, The City of Urbana, The Board of Trustees of the University of Illinois, the Champaign-Urbana Public Health District, and the Champaign County Board of Health.

2.7 **Party; Coordination Group.** A signatory to this Agreement, including an Original Party or one that has become a Party by: 1) approval of this Agreement by its governing body, and 2) acceptance by the original Parties. The Parties, acting through their representatives, shall be the Regional Emergency Coordination Group of Champaign County ("Group").

2.8 **Representatives**. The Parties shall be represented at meetings, during events, or as otherwise needed as follows:

Original Parties:

a. Champaign County - Board Chair, Chief Administrative Officer or their designees;
b. City of Champaign - Mayor and City Manager or designees;
c. City of Urbana - Mayor and Chief Administrative Officer or designees;
d. Board of Trustees of the University of Illinois - Chancellor (Urbana) or designee;
e. Champaign-Urbana Public Health District - Public Health Administrator or designee;
f. Champaign County Board of Health - President or designee; and
g. Others - As identified by its governing body.

2.9 **Support Entity**. Non-party entities or persons that provide information, support and/or services to the Parties during the planning, response to or performance review of Community Emergency Events.

SECTION 3
Core Principles

All activities and decisions of the Group when planning for or responding to a Community Emergency Event shall be governed by the following core principles:

3.1 A coordinated regional approach will provide the most effective protection for all citizens.

3.2 Priorities during a Community Emergency Event shall be based on the preservation of human life, mitigation of property loss, recovery of basic necessary services and protection of the rights of citizens.

3.3 Priorities during Community Emergency Events should be identified by consensus decisions of the Group while recognizing the autonomy and responsibilities of individual Parties within their respective jurisdictions.

3.4 Adequate organization and physical resources should be in place to ensure that the community has the ability to respond to emergencies.

3.5 Elected officials and other administrative policy-making officials should be an integral and consistent part of the policy development and decision-making process.

SECTION 4
Organization

4.1 **Chair; Administrative Officers.** Annually, no later than September 1st of each year, an elected official will be selected to serve as Chair of the Group. The Chief Administrative Officers of the Parties shall be responsible for overseeing the continuing development of a regional emergency plan and regional emergency coordination center, and for implementing any policy directions from the Group.

4.2 **Liaison Responsibilities.** The Liaison will provide timely information to the Group and assist in identifying policy decisions needed. The Liaison shall provide administrative support to the Group. The Liaison shall serve at the pleasure of the Group.

4.3 **Meetings.** The Group shall meet on a quarterly basis or as often as needed. A special or emergency meeting may be called by the Representatives, the Liaison, or an EMA Director in the event of an emergency or other sufficient reason.

a. The following events, when reasonably anticipated, shall be considered sufficient reason for a special or emergency meeting:
   1. Windstorms and tornados
   2. Major flooding
   3. Ice storms and winter blizzards
   4. Earthquakes
   5. Health epidemics or health emergencies
   6. Major chemical or hazardous materials spills
   7. Terrorist events (criminal)

8. Events with significant impact to a major employer, the transportation system, any utility system, or other significant regional facility
9. Radiological events.

b. Operational Emergency Response personnel of the respective Parties may attend meetings to provide information and insight. Support entities may also be invited to attend meetings to provide information and insight to the Parties.

4.4 **Implementation.** The members of the Group may create such other rules, processes, or procedures as will assist the Group in reaching the Goals of this Agreement.

Section 5
Activities

5.1 **Pre-Community Emergency Event Activities**. The Group will endeavor to undertake the following activities prior to a Community Emergency Event:

a. Review State, County and local Emergency Operations Plans to identify any discrepancies and discuss what, if any, updates should be implemented or requested in order to support the principles identified in Section 3;
b. Identify available resources and work closely with operations personnel to determine the best way to allocate resources given the nature of particular Community Emergency Events;
c. Identify and develop any additional plans and/or protocols which might advance the purpose of this Agreement;
d. Establish protocols for providing helpful and consistent information to the public before, during and after a Community Emergency Event;
e. Identify other public or private sector entities that may provide support and insight prior to, during or after a Community Emergency Event;
f. Identify legal authority and/or constraints for securing resources and enacting regulations before, during and after Community Emergency Events; and
g. Jointly facilitate periodic training and practice opportunities for both operations and policy-makers.

5.2 **Activities During a Community Emergency Event**. The Group will endeavor to undertake the following activities during a Community Emergency Event:

a. Provide policy level direction to the Unified Incident Command Staff.
b. Facilitate communication and decision-making between policy makers on a real time basis.
c. Review priorities in the acquisition and allocation of resources based on guiding principles.
d. Reach consensus where possible regarding the imposition of extraordinary regulatory measures (e.g., curfew, evacuations, closings and quarantines and isolations.)
e. Reach consensus on the priorities of emergency activities and in the actual allocation of resources.
f. Review public information and provide guidance to information providers.

5.3 **Post-Community Emergency Event Activities.** The Group will endeavor to undertake the following activities after a Community Emergency Event:

a. Assess activities of all entities during the Event.

b. Coordinate recovery efforts.
c. Review planning documents and agreements to ensure that the documents provide appropriate and effective framework for responses in the future.
d. Exchange information regarding resource expenditures and review efforts to secure reimbursement from federal and state sources.

5.4 **Response to Emergencies.** The Representatives shall be available at all times for response to an emergency. The Representatives shall report to the designated Regional Emergency Coordination Center. The Group shall develop a detailed procedure for calling an emergency meeting of the members. All Representatives shall designate at least two (2) backup designees to act in the event of an emergency.

5.5 **Regional Emergency Coordination Center and Backup Centers.** The Group will work to identify a primary and at least two backup centers.

a. Capabilities of the center shall include: 24/7 operation, sufficient telephone lines with conference call capability, a secure facility, backup power of sufficient size to assure continuing operations, adequate room for staffing, adequate radio, telephone, and internet capabilities.
b. The primary site, unless otherwise designated by the Board, shall be the County Emergency Operations Center.
c. The backup sites include: Champaign City Building Emergency Operations Center and the Emergency Operations Center at Willard Airport.

5.6 **Inclusion of Other Jurisdictions.** The Group shall endeavor to involve in policy-making decisions those elected officials and policy-making administrators of other cities or villages or townships within Champaign County as necessary or desirable, if the impact of the emergency touches on or concerns that jurisdiction.

5.7 **Existing Agreements.** The Parties acknowledge that there are various mutual aid and/or other agreements in force and effect and will endeavor to develop a comprehensive list of such agreements and detail them as Appendix A to this Agreement. The Appendix shall be amended from time to time by the Liaison to reflect its most up-to-date information. The Liaison shall be responsible to distribute the new Appendix A to the Parties after any revision.

5.8 **Future Agreements Implementation and Plans.** The Group will review existing policies, response protocols and other implementation measures to determine if modifications are necessary or desirable to ensure the documents do not materially conflict in ways that will cause confusion during a Community Emergency Event. The Group will at a minimum attempt to review and/or develop the necessary documents to address the following areas:

1. Animal Protection*;
2. Business Continuity;
3. Communications Infrastructure;
4. Communications Among Responders, Emergency Communications System*;
5. Disaster Intelligence/Damage Assessment*;
6. Credentialing;
7. Disease Surveillance;
8. Donations and Volunteer Management;
9. Economic Recovery;
10. Energy (Including Gas, Electric and Backup);

11. Evacuation and Transportation Coordination*;
12. Fire, Technical Rescue, and Hazardous Materials Operations;
13. Food;
14. Hazardous Materials;
15. Health, Mental Health, and Medical Services;
16. Information and Planning;
17. Law Enforcement;
18. Mass Care;
19. Mass Injuries and Mass Fatalities;
20. Mass Vaccination and Distribution of Strategic National Stockpile;
21. Mortuary Services*;
22. Public Information; Media Relations and Community Outreach;
23. Public Works and Engineering
24. Quarantines and Isolations;
25. Resource Management*;
26. Solid Waste and Debris Management;
27. Terrorism;
28. Transportation*;
29. Warnings/Emergency Information;
30. Water Supply Emergency Plan.

* Indicates source is the Illinois Administrative Code Title 29, Chapter 1, Subchapter C, Part 301, Section 301.240

5.9. **Decision Guidelines.** The Parties agree to develop policy-decision guidelines, review them at regular intervals, and utilize them during emergencies.

SECTION 6
General Mutual Aid

6.1 **Mutual Aid.** In the event an occurrence or condition within a party's territorial jurisdiction results in a situation of such magnitude and/or consequence that it cannot be adequately handled by that Party, and there are no specific mutual aid agreements in place, the Party may request assistance from the Group or individual Parties.

6.2 **Request for Assistance**. In the event of an emergency, the requesting party shall request assistance under this Agreement by notifying METCAD and advising of the nature and location of the incident and the assistance requested. METCAD will notify the appropriate responding agencies via telephone or in the most effective way possible.

6.3 **Standard of Assistance.** The National Interagency Incident Management System shall be the standard under which this Agreement and the Parties shall function.

6.4 **Jurisdiction Over Personnel and Equipment.** Personnel sent to aid a party pursuant to this Agreement shall remain employees of the assisting party. The assisting party shall at all times have the right to withdraw any and all aid; provided, however, that the party withdrawing such aid shall notify the requesting party of the withdrawal of such aid and the extent of such withdrawal.

6.5 **Compensation for Aid.** Nothing in this Agreement shall preclude responding parties from receiving compensation for equipment, personnel, or services from any state or federal

agency or any third-party, under existing statutes, rules and regulations; provided, however, that unless such compensation from the state or federal government is available, the Parties agree to waive compensation for assistance rendered.

6.6 **Indemnification.** Each Party hereto agrees to waive all claims against all other Parties hereto for any loss, damage, personal injury or death occurring in consequences of the performance of mutual aid services, however, that such claim is not a result of gross negligence or willful misconduct by a party hereto or its employees or agents.

Each Party requesting or providing aid pursuant to this Agreement hereby expressly agrees, to the extent permitted by Illinois law, to hold harmless, indemnify and defend the party rendering aid and its personnel from any and all claims, demands, liability, losses, suits in law, or in equity which are made by a third party, or its own employees, provided that such claims, demands, liabilities, losses, suits in law or in equity made by a third party, or employees, are not the result of gross negligence or willful misconduct on the part of the party rendering aid. All employee benefits, wages and disability payments, pensions, workers compensation claims, damage to or destruction of equipment and clothing, and medical expenses of the party, or its employees, rendering aid shall be the sole and exclusive responsibility of the respective Party of its employees.

Section 7
Miscellaneous Provisions

7.1 **Term; Notice.** This Agreement shall be in effect for a term of one year from the date of the last signature hereof and shall automatically renew for successive one-year terms unless terminated in accordance with this section. Any party hereto may terminate its participation in this Agreement at any time, provided that the party wishing to terminate its participation in this Agreement shall give written notice to the Parties participating in this Agreement specifying the date of termination. Such notice to be given at least ninety (90) calendar days prior to the specified date of termination of participation. The written notice provided herein shall be given by personal delivery, registered mail or certified mail.

Notice shall be as follows:

City of Champaign
Attn: City Manager
102 North Neil Street
Champaign, IL 61820

City of Urbana
Attn: Mayor
400 South Vine Street
Urbana, IL 61801

Champaign County
Attn: County Board Chair
1776 East Washington
Urbana, IL 61802

University of Illinois
Attn: Chancellor
601 East John Street, Swanlund Bldg.
Champaign, IL 61820

Champaign-Urbana Public Health District
Attn: Public Health Administrator
201 W. Kenyon Road
Champaign, IL 61820

Champaign County Board of Health
Attn: Board President
1776 East Washington
Urbana, IL 61802

7.2 **Effectiveness.** This Agreement shall be in full force and effect upon approval by the Parties hereto in the manner provided by law and upon proper execution hereof.

7.3 **Validity.** The invalidity of any provision of this Agreement shall not render invalid any other provision. If for any reason, any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable that provision shall be deemed severable and this Agreement may be enforced with that provision severed or modified by court order.

7.4 **Governing Law.** This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of Illinois.

7.5 **Amendments.** This Agreement may only be amended by written consent of all the Parties hereto.

7.6 **Counterparts.** This Agreement may be executed in several counterparts, each of which shall be deemed an original and all such counterparts together shall constitute one and the same instrument.

[THIS SPACE INTENTIONALLY LEFT BLANK]

IN WITNESS WHEREOF, the Parties have adopted and subscribed to and approve this Agreement and have caused it to be duly executed.

CITY OF CHAMPAIGN, ILLINOIS By:_____ City Manager ATTEST:_____ Date:_____ APPROVED AS TO FORM: _____ City Attorney CB 2007-	**CITY OF URBANA, ILLINOIS** By:_____ Mayor ATTEST:_____ Date:_____ APPROVED AS TO FORM: _____ City Attorney Ord:
COUNTY OF CHAMPAIGN, ILLINOIS By:_____ Chair, County Board ATTEST:_____ County Clerk Date:_____ APPROVED AS TO FORM: _____ State's Attorney	**BOARD OF TRUSTEES OF THE UNIVERSITY OF ILLINOIS** By:_____ Comptroller ATTEST:_____ Secretary Date:_____ APPROVED AS TO FORM: _____ University Counsel
CHAMPAIGN-URBANA PUBLIC HEALTH DISTRICT By:_____ Chair, Board of Health ATTEST:_____ Secretary Date:_____ APPROVED AS TO FORM _____ Attorney	**CHAMPAIGN COUNTY BOARD OF HEALTH** By:_____ President ATTEST:_____ Secretary Date:_____ APPROVED AS TO FORM: _____ Attorney

APPENDIX A
As of _____, 2007

Champaign:

1. An Agreement for Police Services (CB 82-52)
2. Five Agreements for Extending Fire Dispatching Services (City of Urbana; Village of Savoy; Carroll, Eastern Prairie, Edge-Scott Fire Protection Districts) (CB 88-260)
3. An Intergovernmental Agreement Creating the Champaign County Emergency Telephone System Board (CB 89-128)
4. An Agreement Concerning the Provision and Administration of Metropolitan Computer-Aided Dispatch (METCAD) By and Between the City of Champaign, the City of Urbana, Champaign County, and the University of Illinois (CB 95-255) and Amendment No. 1 to Agreement Concerning the Provision and Administration of Metropolitan Computer Aided Dispatch (METCAD) (CB 98-311)
5. Intergovernmental Agreement Between the Cities of Champaign and Urbana (Fire Protection Mutual Assistance Agreement) (CB 98-57)
6. MABAS (Mutual Aid Box Alarm System), an Intergovernmental Agreement with Other Fire Departments and Emergency Service Agencies to Provide Fire and Other Emergency Services and Assistance (CB 01-174)
7 East Central Illinois Mutual Aid System Agreement (CB 01-223)

Urbana:

Champaign County:

1. A Resolution Creating a County Civil Defense Agency (Resolution Number 12)
2. An Ordinance Establishing the Emergency Services and Disaster Agency of Champaign County (Ordinance Number 12)
3. A Resolution for the Establishment of an Amateur Radio Communication Station for Champaign County (Resolution Number 189)
4. An Ordinance Establishing the Emergency Services and Disaster Agency of Champaign County (Ordinance Number 342)
5. An Ordinance Re-Establishing the Emergency Services and Disaster Agency of Champaign County as the Emergency Management Agency of Champaign County (Ordinance Number 740)
6. An Agreement for Police Services By and Between the City of Champaign, the City of Urbana, the County of Champaign, and the University of Illinois (Resolution Number 2009)
7. A Resolution Establishing County Board Position with Regard to Location of METCAD at 1905 E. Main, Urbana, Illinois, Resolution Number 4141
8. A Resolution to Adopt the National Incident Management System in Champaign County, Illinois (Resolution Number 4888)
9. A Resolution Authorizing Participation as a Member in the Illinois Emergency Management Mutual Aid System (Resolution Number 4945)

University of Illinois:

Champaign-Urbana Public Health District

Champaign County Public Health Board

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RENEWAL OF PARTICIPATION AGREEMENT

WHEREAS, the Champaign County Health Department, through its duly authorized agent, the Champaign County Board of Health, hereinafter known as the "Board", and Central Illinois Dental Education and Services, hereinafter known as "CIDES", entered into a Participation Agreement dated December 15, 2005, a copy of which is attached to this Renewal of Participation Agreement and marked as "Exhibit A"; and

WHEREAS, the Champaign County Board has approved its budget for the County's Fiscal Year from December 1, 2007 to November 30, 2008 in which it has included a grant for the cost of the renewal of the Participation Agreement between the Board and CIDES in the amount of $130,360; and

WHEREAS, the Board believes it is in the best interest of residents served by the Champaign County Health Department that the Participation Agreement should be renewed for the period December 1, 2007 to November 30, 2008, with all of the terms and conditions previously contained in the Participation Agreement attached to this Renewal of Participation Agreement and marked as "Exhibit A", with the following exceptions:

1. The Board and CIDES agree that should CIDES merge with the Champaign-Urbana Public Health District or any other entity during the term of this Renewal of Participation Agreement, or alternatively should the services presently performed by CIDES be subsumed by the Champaign-Urbana Public Health District, the parties shall modify the terms and conditions of this Renewal of Participation Agreement as necessitated by the said merger or take-over;

2. The Board and CIDES agree that none of the monies paid by the Board to CIDES for the services outlined in the Participation Agreement shall be used by CIDES for any services they provide to residents of the Lincoln's Challenge Program; and

WHEREAS, the Board and CIDES agree that the annual contract cost for the renewal of the Participation Agreement shall be the sum of $130,360;

The Champaign County Board of Health and Central Illinois Dental Education and Services enter into this Renewal of Participation Agreement for the period December 1, 2007 to November 30, 2008 in the amount of $130,360, with the monthly payments to

be $10,863.33 per month, and with the said Renewal to be pursuant to the remaining terms and conditions outlined in this Renewal of Participation Agreement and the attached "Exhibit A", on this _____ day of _____, 2007.

CHAMPAIGN COUNTY HEALTH DEPARTMENT

BY:_____
Chair, Champaign County Board of Health

CENTRAL ILLINOIS DENTAL EDUCATION AND SERVICES, NFP

BY:_____
President, Board of Central Illinois Education and Services, NFP

Prepared by:

Susan W. McGrath
Senior Assistant State's Attorney
Office of the Champaign County State's Attorney
1776 E. Washington
Urbana, IL 61802
217/384-3776

PARTICIPATION AGREEMENT

WHEREAS, Central Illinois Dental Education and Services, hereinafter known as "CIDES", is a not for profit corporation organized and existing under the laws of the State of Illinois and in good standing; and

WHEREAS, CIDES has organized and coordinates a program involving the recruitment of area dentists and dental hygienists who are willing to provide low cost dental hygiene services to children for whom such services might otherwise be unavailable; and

WHEREAS, the Champaign County Health Department, hereinafter known as "DEPARTMENT", is a duly organized and existing County Health Department; and

WHEREAS the DEPARTMENT and CIDES had previously entered into agreements for the participation of children residing outside of the Champaign-Urbana Public Health District service area in the program organized and coordinated by CIDES; and

WHEREAS, the program established and coordinated by CIDES results in low cost dental hygiene services being provided to such children without cost to them; and WHEREAS, said dentists and dental hygienists have agreed to participate in said program and to accept as full and final payment for their services, payments below the market value for those services as a result of their desire to assure that such services are provided to said children; and

WHEREAS, CIDES' program has resulted in the education of county residents on the importance of dental hygiene and dental care; and

WHEREAS, CIDES has engaged in out-reach efforts to generate community support and increased access to dental providers for eligible children; and WHEREAS, CIDES has coordinated and organized screenings and evaluations of such children by registered dental hygienist in

accordance with the Dental Practice Act; and

WHEREAS, the DEPARTMENT wishes to continue it's pre-existing relationship with CIDES so as to ensure that eligible county children and families are provided access to education and services, the DEPARTMENT and CIDES hereby enter into this agreement as follows:

1. The term of this agreement commences on the date of approval by both CIDES and the DEPARTMENT and shall continue in full force and effect until November 30th, 2006 unless otherwise terminated as provided for herein.
2. The DEPARTMENT and CIDES may mutually agree to extend the term of this agreement at any time or to enter into a new agreement at any time prior to November 30th, 2006, but there shall be no automatic renewal of this agreement absent such mutual assent.
3. The DEPARTMENT shall pay to CIDES the sum of $105,168.00 in equal monthly installments of $8,764.00 per month payable on or before the 1st day of each month during the term of this agreement, with the first such payment hereunder to be prorated so as to insure that the total payment for December 2005 pursuant to this agreement and the existing agreements equals but does not exceed $8,764.00.
4. CIDES shall, for all intents and purposes, be an independent contractor and shall, for no purposes, be considered to be in a joint venture relationship with the DEPARTMENT; and furthermore no employee or independent contractor of CIDES shall be considered to have a joint venture or an employer-employee relationship with the DEPARTMENT.

5. CIDES shall be solely responsible for the payment of all payroll, taxes, Social Security payments, unemployment payments, and all other financial obligations in the performance of this agreement, including obligations for personnel hired by CIDES to perform the services set forth herein.

6. CIDES shall not, without prior authorization from the DEPARTMENT, submit any grants on behalf of the DEPARTMENT, and nothing in this agreement shall be construed as rendering CIDES an agent of the Department for such purposes absent such prior authorization.

7. CIDES shall provide to the DEPARTMENT a copy of it's annual audit within (30) days after the said audit is completed and available for distribution.

8. CIDES shall provide to the DEPARTMENT contact information, including a telephone number at which the public can contact CIDES concerning the program offered by it, including the access and education services provided pursuant to this agreement and shall implement a system by which the public can communicate with representatives of CIDES concerning said program and access thereto at reasonable times. It is the intent of the parties, absent unforseen circumstances, that contacts to CIDES by members of the public shall be responded to within (1) regular business day following the receipt of said requests.

9. It shall be the sole responsibility of CIDES to ensure the adequacy of it's staff and that all participating dentists and dental hygienists have appropriate professional certifications to provide the services to be under the CIDES program.

10. The DEPARTMENT shall have not be deemed to be a party to any agreements for

the provision of said services nor in anyway to be responsible for the sufficiency of said services or the manner in which they are provided. Instead, it is the express intent of the parties hereto that the DEPARTMENT is contracting with CIDES to ensure access to the program and educational services provided by CIDES for county residents and, in no manner, shall the DEPARTMENT be deemed to have any obligation to exercise control or responsibility for the provision of any services organized by CIDES.

11. The DEPARTMENT and CIDES expressly acknowledge, however, that the DEPARTMENT has a substantial interest in assuring that the children sought to be served by participation with CIDES are adequate in number and level of service in light of the compensation provided hereunder and thus CIDES shall provide to the DEPARTMENT monthly reports at the DEPARTMENT's regular Board meetings which shall include information concerning the number of children served pursuant to participation in this agreement; a brief description of the services provided; and such other further and additional information, if any, reasonably requested by the DEPARTMENT through it's Board, so as to enable the DEPARTMENT to be fully informed with respect to the type, manner, and number of services being provided hereunder. Such further additional information may include, if necessary for the DEPARTMENT to fulfill it's review of services provided, financial information, to the extent that the same reflects upon the provision of services hereunder.

12. CIDES shall maintain, at it's own expense, such insurance, including worker's compensation insurance, liability insurance, and other such insurance as it deems

necessary and shall provide a certificate of such insurance to the DEPARTMENT upon execution of this agreement. The provision of said certificate shall be for information purposes only and shall not be deemed to constitute a relationship of any type or nature other than the contractual relationship provided for hereunder.

13. CIDES represents, however, that it has and shall maintain liability insurance in an amount not less than $1,000,000.00 per occurrence and such worker's compensation insurance as required by Illinois Law.

14. CIDES and the DEPARTMENT further agree that should either party fail to fulfill it's obligations hereunder the other party may bring an action to specifically enforce the obligations hereunder, but that such an action shall not exclude the availability of any other remedy permitted by law.

15. In the event that either party fails to fulfill it's respective obligations, the party claiming such breach shall provide notice to the purportedly breaching party and shall afford that party and opportunity to remedy said breach or for the parties to reach an agreement with respect thereto of not less than (14) days following the effective date of service. Service shall be deemed effective upon actual receipt by personal delivery by service upon the registered agent or any officer of CIDES or personal service upon the Chair of the Champaign County Board of Health, or it's administrator.

16. CIDES and the DEPARTMENT further agree that the nature of the agreement provided for herein is in the nature of a personal services contract and thus CIDES shall not assign or delegate it's contractual responsibilities and obligations hereunder

to any third party without the express written consent of the DEPARTMENT.

17. CIDES and the DEPARTMENT further agree that neither the dentists nor dental hygienists who are participating in the program organized and administrated by CIDES, nor any child for whom services thereunder may be provided, are or shall be deemed to be third party beneficiaries, intended or otherwise, of this agreement; that nothing herein shall be construed to create any relationship between CIDES and the DEPARTMENT other than as an independent contractor; that nothing shall be construed herein, or interpreted, to provide that the DEPARTMENT or CIDES are providing dental hygiene services, but instead shall be construed and interpreted so as to ensure that the scope and extent of the DEPARTMENT's involvement in the provision of services recruited and organized by CIDES is for the purpose of ensuring access for said eligible children and public education.

18. This agreement shall be interpreted, construed, and enforced in accordance with the provisions of applicable Illinois Law.

19. This agreement contains the entirety of the parties agreement regarding the relationship established hereby and no prior discussions, negotiations, or agreements are a part hereof the same being conclusively deemed to have merged herein.

CENTRAL ILLINOIS DENTAL EDUCATION SERVICES, NFP, AN ILLINOIS NOT FOR PROFIT CORPORATION,

BY: William Mueller
President 12/15/05

CHAMPAIGN COUNTY HEALTH DEPARTMENT,

BY: H. D. Wright Jr.
Chair, Champaign County Board of Health

Prepared by:
Robert G. Kirchner
Attorney at Law
100 Trade Centre Drive, Suite 402

Champaign, IL 61820
Phone: 217-355-5660
Fax: 217-355-5675
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BOARD OF HEALTH CALENDAR RECOMMENDATION FOR JANUARY 1, 2008 – NOVEMBER 30, 2008

All meetings are held at Brookens Administrative Center, 1776 E. Washington St, Urbana in Meeting Room 3, unless otherwise noted.

January 15, 2008	6:00 p.m. – Open Date for Board of Health Study Session
January 29, 2008	6:00 p.m. – Board of Health Meeting
February 12, 2008	6:00 p.m. – Open Date for Board of Health Study Session
February 26, 2008	6:00 p.m. – Board of Health Meeting
March 11, 2008	6:00 p.m. – Open Date for Board of Health Study Session
March 25, 2008	6:00 p.m. – Board of Health Meeting
April 15, 2008	6:00 p.m. – Open Date for Board of Health Study Session
April 29, 2008	6:00 p.m. – Board of Health Meeting
May 13, 2008	6:00 p.m. – Open Date for Board of Health Study Session
May 19, 2008	**11:00 a.m. – Budget Subcommittee Meeting**
May 27, 2008	6:00 p.m. – Board of Health Meeting
June 17, 2008	6:00 p.m. – Open Date for Board of Health Study Session
June 16, 2008	**11:00 a.m. – Budget Subcommittee Meeting**
June 24, 2008	6:00 p.m. – Board of Health Meeting
July 15, 2008	6:00 p.m. – Open Date for Board of Health Study Session
July 21, 2008	**11:00 a.m. – Budget Subcommittee Meeting**
July 29, 2008	6:00 p.m. – Board of Health Meeting
August 12, 2008	6:00 p.m. – Open Date for Board of Health Study Session
August 26, 2008	6:00 p.m. – Board of Health Meeting
September 16, 2008	6:00 p.m. – Open Date for Board of Health Study Session
September 30, 2008	6:00 p.m. – Board of Health Meeting
October 14, 2008	6:00 p.m. – Open Date for Board of Health Study Session
October 28, 2008	6:00 p.m. – Board of Health Meeting
November 11, 2008	6:00 p.m. – Open Date for Board of Health Study Session
November 25, 2008	6:00 p.m. – Board of Health Meeting

DOCUMENTS DISTRIBUTED AT THE NOVEMBER 27, 2007 BOARD OF HEALTH MEETING

Contents:

Decision Memorandum

DATE: December 4, 2007
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Peter Tracy
SUBJECT: Public Health Collaboration – Out-of-Cycle Funding

At the September 2007 CCMHB meeting, Dr. Julian Rappaport made a brief presentation about collaboration between the Champaign County Public Health Department (CCPHD) and the CCMHB. Specifically, the CCPHD has allocated $25,000 to proceed with a jointly sponsored project with the expectation that we would match their allocation. There has been discussion about integrated planning between mental health and public health since the 2006 consultation with Harry Shallcross, Ph.D., along with subsequent conversations between Dr. Rappaport, Dr. Moore and myself concerning opportunities for collaboration and funding partnerships. It is now time to take action.

Collaboration Options:

There are many areas of overlap between public health and mental health and several obvious possibilities for a "first-step" jointly funded service/program. The following is a brief summary of three opportunities which could be considered to address unmet mental health/physical health needs in our community.

Maternal Depression: The frequency of occurrence of a variety of mood disorders in new mothers--ranging from modest adjustment crises to psychosis--continues to rise. A variety of explanations has been offered, but most promising seem to be the problems wrought by social isolation (created by living circumstances, transience, lack of proximity to family-of-origin, and a general tendency toward living in greater isolation in the United States), and by technological childbirth (which has resulted in very short hospital stays--cutting off the education and support once offered by nursing staff and other mothers, during a customary stay of three days or more--as well as very high c-section rates--now approaching one out of three deliveries in America--which appear to result in lowered maternal self-efficacy and increased pain, anxiety, and sorrow). A variety of treatment options have emerged, including postpartum support groups, parent-infant play groups, and medication (which is now very widely used, at enormous cost to the parent and to society). A home visitor model of prevention would break the cycle of social isolation, restore the postpartum education that served as a major source of support for new mothers for generations, and serve early detection and case management purposes, all at a very low cost. Perhaps most impressive of all, such a home visitor

model would avoid the pathologizing of maternal reactions to her new role, would reduce community stigmatization of postpartum mood disorders, and begin to create a circle of security for mothers that would serve to prevent the child abuse that often results from such mood disorders, would reduce the rate of re-occurrence with subsequent pregnancies, and would reduce the needs for (and the resulting side effects of) maternal use of psychotropic medications.

Depression in the Elderly and Older Adults – Depression is not a normal or necessary part of aging and most seniors are happy with their lives even though there are unique challenges which must be addressed. Social isolation, the deaths of friends or family, and health issues can precipitate depression. Without support and/or treatment, depression keeps seniors from enjoying life and can also have an adverse impact on their health. The National Institutes of Health report of the 35 million Americans age 65 or older, roughly 2 million suffer from serious depression. Unfortunately, only a small percentage of seniors with depression receive the help they need and untreated depression results in serious risks including illness, substance abuse (i.e., alcohol, prescription drug, etc.), higher mortality rates, and suicide. Again, it is important to stress that depression is NOT a normal part of the aging process and people should not have to live with depression. It is also important to understand that seniors do not always fit the typical profile of depression and often claim they don't feel sad. Instead, they may present with low energy, reduced motivation, physical complaints (e.g., worsening headaches or arthritis pain), increased anxiety, irritability, poor personal hygiene, reduced sense of purpose, and obsessive concerns about money, health, or the state of the world. There is also a reluctance to talk about feelings or request assistance. A home visitor model with mental health assessment and support could be an effective way to address this serious and underserved problem.

School-Based Health Centers – The CCMHB currently partners with the Champaign Urbana Public Health District (CUPHD) to operate the school-based health center with Urbana Public Schools. This program provides a combination of physical health, dental health, and mental health services in a single location. There is a need to expand the availability of school-based health services to location outside of the cities of Champaign and Urbana. Key informant information has identified the Village of Rantoul as a high need area that could benefit from a school based health center.

Summary and Recommendations:

1. Taking action at this time to commit dollars to partner with the Champaign County Public Health Department would constitute an out-of-cycle allocation, and thereby requires the CCMHB to authorize an exception to Funding Guidelines.
2. The CCMHB should authorize $25,000 to match the amount allocated by the Champaign County Public Health Department for a jointly sponsored project involving the integration of physical and behavioral health services.
3. The CCMHB represented by Dr. Thom Moore and the CCPHD represented by Dr. Julian Rappaport, in collaboration with the CCMHB executive director should proceed with a process to plan and implement a jointly sponsored project related to one of the three opportunities described above.

Decision Section:
Motion to approve the authorization for out-of-cycle funding of $25,000 to implement a jointly funded project between the CCMHB and the CCPHD as described in the recommendations listed above.

_____ Approved

_____ Denied

_____ Approved with Modifications

_____ More Information is Needed

Contract Boilerplate

CHAMPAIGN COUNTY MENTAL HEALTH BOARD
FY08 Contract

Contract # Descriptor Code

Contract/Program Name:

Contract Maximum:

This Contract is by and between the **Champaign County Mental Health Board**, hereinafter referred to as the "**Board**," and hereinafter referred to as "Provider," with principal address at

The Board and Provider each agrees:

A. Type of Contract (Check one below)

____ Grant
Attachments Required: Program Plan____; Budget____; Rate Schedule____; Payment Schedule____; Other (specify)_____

_____ Purchase of Service / Fee for Service
Attachments Required: Program Plan____; Budget____; Rate Schedule____; Payment Schedule _____; Other (specify)_____

_____ Special Initiative
Attachments Required: Program Plan____; Budget____; Rate Schedule____; Payment Schedule _____; Other (specify)_____

_____ Consultation
Attachments Required: Program Plan____; Rate Schedule____; Payment Schedule; _____; Other (specify) _____

_____ Capital Improvement
Attachments Required: Proposal____; Budget____; Payment Schedule _____; Other (specify) _____

_____ Juvenile Justice Post-Detention
Attachments Required: Program Plan____; Budget____; Rate Schedule _____; Payment Schedule _____; Other (specify) _____

B. Special Provisions

C. Contract Boilerplate, all contracts:

1. This Contract shall be effective July 1, 2007 and shall expire on June 30, 2008. Costs incurred prior to the effective date hereof, after the expiration date hereof, or after earlier termination pursuant to the provisions of the Contract, shall not be paid by the Board. This Contract and the exhibits hereto contained shall not be binding and enforceable unless signed by all parties, including the executive director of the Board and the President of the Board.

2. The maximum amount payable under this Contract is $

3. The Board shall pay the Provider by and through the Champaign County Treasurer.

4. Grant based contracts: Monthly payments will be paid based on the total contract amount divided by the length of the contract in equal installments. If multiple rates or special payment arrangements apply, the attachment entitled Payment Rate Schedule, is attached hereto and incorporated by reference.

   Fee for Service Contracts: The Provider shall submit a Monthly Billing Statement for the services provided at the appropriate rate(s) as stated in the contract. Statements are due into the CCMHB office no later than the 15th of the month following the end of the month in which the services were delivered.

   The provider shall be paid 1/12 (one twelfth) of the contract maximum for each month during the first five months of the term of this contract (i.e., July, August, September, October and November), and these payments shall be reconciled against actual billings in December. If overpayment has occurred, future payment will be withheld until such time as monthly billing statements justify additional payment. No monthly payment shall exceed the pro-rated monthly allocation, except when year-to-date billings have fallen short of the allowed maximum available. Credits will **not** be carried over upon the completion of the agency's fiscal year.

   Record review – Adjustments to Purchase of Service/Fee for Service Reimbursement. A minimum sample of (five) or 5% of average monthly cases billed to the Board (whichever is greater) shall be reviewed no less than annually. The Provider shall be subject to adjustment in approved reimbursement if the Board and the Provider staff agree a given unit of service has been erroneously billed. The Board may require repayment of the funds already paid to the Provider for those

units found to be in error or may require the Provider to deduct erroneous amounts from future billings. An error rate above 5% in the initial sample may be cause for drawing another sample of cases subject to the same rules of procedure as above. The Board reserves the right to decrease the maximum amount payable if:

1. Staff and or consultants are not hired within 30 days after the effective date of this Contract, or the projected hire date, or if a vacancy occurs.
2. Line items are not expended according to the schedule as evidenced in expense reports, if an acceptable amendment is not submitted within 30 days following the submission of the expense report.

Any funds which are not used or expended at the end of the Contract period in accordance with the terms and conditions of this contract, shall be returned to the Board within 45 days after the expiration of this Contract.

5. Taxpayer Certification:
Under penalties of perjury, the person signing this Contract on behalf of the Provider personally certifies that _____ is the correct Federal Taxpayer Identification Number (FEIN); or, NA is the correct Social Security Number for the Provider doing business as indicated below: (please check one).

(Note: Sole proprietorship must use Social Security Number)

_____ Individual	_____ Sole Proprietorship	_____ Corporation
_____Not for Profit Corp.	_____ Tax Exempt Org	_____ Partnership
_____ Governmental Entity	_____ Medical Health Care Services Provider Corp	

6. Employment Status
Unless otherwise specified in the Contract, the Provider does not acquire any employment rights with the Board or Champaign County by virtue of this Contract. Payments made are not subject to income tax withholding and do not entitle the Provider to any benefits afforded employees of the Board or Champaign County.

7. Address Change
The Provider will provide written notice of any change(s) of principal office/mailing address at least 30 days in advance of the change. Written notice of changes of name, ownership, taxpayer I.D. or taxpayer certification should be provided at least 45 days in advance and such changes will require new contracts to be written.

8. Services

In consideration of the mutual promises, covenants, and undertakings of the parties hereto, the Provider agrees to provide services as stipulated in the Program Plan attached hereto and incorporated herein by reference.

In the event of a conflict between the provisions of the Contract and the Program Plan, the provisions of the Program Plan apply.

9. Confidentiality
   All records and other information obtained by the Provider concerning persons served under this Contract is confidential pursuant to State and Federal statues, and shall be protected by the Provider from unauthorized disclosure.

10. Record Keeping and Monitoring
    a. The Provider is required to maintain books and records relating to the performance of this Contract and necessary to support amounts charged to the Board under this Contract. The books and records shall be maintained for a period of three years from the expiration date and final payment under the Contract.
    b. All books and records required to be maintained under subsection (a) of this paragraph shall be available for review and audit by the Board. The Provider is required to fully cooperate with any audit initiated by the Board.
    c. Failure of the Provider under this Contract to maintain the books and records required by subsection (a) of this paragraph shall establish a presumption in favor of the Board for the recovery of any funds paid by the Board for which the required books and records are not available.
    d. The Provider shall maintain all such other records as may be required by the Board.
    e. The Provider shall assist the Board in its functions of monitoring and evaluating performance under this Contract. The Provider shall allow Board employees total access to all records, financial and programmatic, relating to this Contract. At a minimum, the Provider will submit Quarterly Service Reports in a format specified by the CCMHB. The report will specify, at a minimum, unit(s) of service volume delivered for the period. Expected volume shall be written into the Program Plan. Quarterly Service Reports covering the previous 3 months activities are due on October 15, January 15, April 15 and July 15. Program(s) will be considered non-compliant if these reports are not submitted by the end of the month when due.
    f. The Provider's books of account shall be kept in accordance with the Standards of Accounting and Financial Reporting for Voluntary Health and Welfare Organizations, or other methods which are consistent with generally accepted accounting standards. Accrual accounting is required for all financial reporting.

g. The Provider shall keep true and accurate financial records reflecting all financial transactions pursuant to this Contract.
h. The Provider shall maintain time and attendance records for all staff whose salaries are funded in whole or in part pursuant to this Contract consistent with generally accepted business practices.
i. Except in emergency situations, the Board will attempt to provide to the Provider five days notice of its intent to review financial and programmatic records relating to this Contract, including, but not limited to, those records specified by this paragraph and all other parts of this Contract. Regarding those records related to this Contract, the Provider shall grant complete access to those Board employees or other qualified persons who are authorized by the Board or otherwise by law.

11. Payment

Obligations of the Board will cease immediately without penalty or further payment being required if in any fiscal year the tax that is levied, collected and paid into the "Community Mental Health Fund" is not sufficient for payment as delineated in the terms and conditions under this Contract.

The Board shall exercise the right to withhold monthly payments until required reports and/or forms are received and approved.

The Provider agrees that the Board reserves the right to correct any mathematical or computational error in the payment subtotals or total contract obligation by the Board to the Provider.

12. Audit Requirements

(a) Each agency is required to have an annual audit unless otherwise waived by CCMHB, as of the close of its fiscal year. This audit is to be performed in accordance with generally accepted auditing standards by an independent certified public accountant registered by the State of Illinois. The resultant audit report is to be prepared in accordance with generally accepted auditing standards and "Government Auditing Standards," issued by the Comptroller General of the United States. The report shall contain the basic financial statements presenting the financial position of the agency, the results of its operations and changes in fund balances. The report shall also contain the auditor's opinion regarding the financial statements, taken as a whole, or an assertion to the effect that an opinion cannot be expressed. If the auditor expressed a qualified opinion, a disclaimer of opinion, or an adverse opinion, the reason therefore must be stated.

(b) The following supplementary financial information shall be included in the audit reports: (Failure to do so will make the report unacceptable.)

- Schedule of Operating Income by Program: This schedule is to be developed using CCMHB approved source classification. Individual sources of income should not be combined. Example: Funds received from several state or federal agencies should not be combined into one classification, such as "State of Illinois" or "Federal Government."
- Schedule of Operating Expenses by Program: The Certified Public Accountant should develop the Expenses by Program Statement using CCMHB approved operating expenses categories. The statement is to reflect program expenses in accordance with CCMHB reporting requirements including the reasonable allocation of administrative expenses to the various programs.
- Filing of Audit Report: The audit report is to be filed with the CCMHB within 120 days of the end of the agency's fiscal year. In order to facilitate meeting filing requirements, agencies are encouraged to contract with certified public accountants before the end of the fiscal year.
- Request for Exceptions: A request for exceptions to these audit requirements or for an extension of time to file the audit report must be submitted, in writing, to the executive director of the CCMHB. In all cases, approval shall be obtained prior to extensions and/or exceptions being implemented.
- Penalty: Failure to meet these audit requirements shall be cause for termination or suspension of CCMHB funding.
- Records: All fiscal and service records must be maintained for five years after the end of each budget period, and if need still remains, such as unresolved issues arising from an audit, related records must be retained until the matter is completely resolved.

(h) At the discretion of the CCMHB, audit requirements may be waived for contracts with consultants, family support groups or other special circumstances. The waiver provision shall be specified in the contract.

For additional information, please refer to the CCMHB Funding Guidelines.

13. Financial Reports

On or before the last Friday of the month following the completion of each calendar quarter, the Provider will deliver to the Board a quarterly fiscal report using the forms provided by the Board for that purpose. Quarterly financial reports are to be cumulative for the current reporting year. The Provider will be considered out of contract compliance if these reports are not submitted when they are due. Payments due to the Provider by the Board pursuant to this Contract shall be withheld if reports are not submitted on a timely basis by the Provider to the Board.

14. Excess Revenue

At the end date of this Contract, the Provider shall be required to return any funds they have been paid pursuant to this Contract in excess of what is due to the Provider at termination, in accordance with existing Board rules and contractual obligations.

15. Termination
    a. Each party reserves the right to terminate this Contract at any time for any reason, upon 30 days written notice to the other party.
    b. This Contract shall be deemed to have been breached by the Provider if it fails to perform any material act mandated by this Contract; and, at that time the Board may terminate this Contract immediately upon notice. The termination shall be effective upon the date notice is mailed in a properly addressed envelope with postage prepaid and deposited in a United States Post Office or post office box or hand delivered to the Provider's principal address listed herein.
    c. Upon termination of this Contract, any equipment exceeding $500 in value at the time of purchase which was purchased with Board funds shall be returned to the Board within 90 days, unless otherwise agreed to in writing signed by the executive director or president of the Board.

    Upon termination of this Contract prior to the end date provided by the terms of this Contract, the Provider shall return to the Board all revenues in excess of expenses as of the date of termination. Such return shall be by check payable to the Board, no later than 15 days after completion of the required audit.

16. Severability
    In the event any provision of this Contract is declared void, voidable or otherwise unenforceable, then such provision, term or condition shall be severable from this Contract and this Contract shall otherwise be fully effective, binding and enforceable.

17. Meetings and Trainings
    The Provider agrees to provide training to meet the training needs of the staff providing services under this Contract.

    The Provider agrees to release the appropriate staff and/or administrative representative from duties and budget adequate funds to allow staff to attend trainings and/or meetings provided by the Board.

    The Provider agrees to full participation in monthly meetings of the Mental Health Agencies Council (MHAC) meetings sponsored by the Board. The Provider will be represented at MHAC meetings by the executive director or chief executive officer, or appropriate designee.

18. Personnel

The Provider attests that all personnel who directly provide services under this Contract are fully qualified to carry out their duties, and that all representations concerning Provider personnel (academic credentials, work experience, number of staff, etc.) are true and correct. The Provider shall remain in compliance at all times with the standards prescribed by state and federal law for the rendering of such services.

The Provider will develop job descriptions and staff development plans for all Board funded (total or partial) positions (including volunteers). Job descriptions will be kept on file at the Providers site and made available to Board staff upon request.

The Provider will notify the Board in writing of all staff changes. Notification must occur as soon as changes are anticipated or upon notification of resignation or termination.

19. Subcontracts

This Contract, or any part thereof, shall not be subcontracted, assigned or delegated without prior written consent of the Board.

Professional services subcontracted for shall be provided pursuant to a written contract, and shall be subject to all provisions contained in this Contract. The Provider shall remain responsible for the performance of any person, organization, or corporation with which it contracts.

20. Compliance with State and Federal Laws

This Contract, and all subcontracts entered into pursuant to this Contract, shall be governed by the laws of the State of Illinois and insofar as applicable, by related Federal laws and regulations. The provider agrees to timely comply with all Local, State and Federal laws, regulations and standards pertaining to the Program Plan and all other matters contained in this Contract.

The Provider agrees to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they pertain to covered treatment services including but not limited to: maintaining protected health information, disclosing protected health information, engaging in billing third parties for treatment services, providing notices of privacy to patients receiving treatment services through covered programs, and maintaining disclosure authorizations for patients enrolled in covered services. Further, the Provider agrees to accept this contract as a business associate agreement with the Champaign County Mental Health Board for any and all disclosure of protected health information between the Provider and the Champaign County Mental Health Board.

The Provider certifies that he/she is in compliance with all applicable Federal, State and Local laws protecting the civil rights of persons.

The Provider certifies that he/she is in compliance with the State and Federal constitutions, the Illinois Human Rights Act, the United States Civil Rights Act, and Section 504 of the Federal Rehabilitation Act. The Provider, its employees, and subcontractors shall comply with all applicable provisions of the following State and Federal laws and regulation pertaining to nondiscrimination and equal employment opportunity including but not limited to the delivery of services under this Contract and all subsequent amendments thereto:

a. The Illinois Human Rights Act, as now or hereafter amended (775 ILCS 5/1 – 101 et seq.);
b. Public Works Employment Discrimination Act "to prohibit discrimination and intimidation on account of race, creed, color, sex, religion, physical or mental handicap unrelated to ability, or national origin in employment agreements for public buildings or public works." (775 ILCS 10/0.01 et seq.);
c. The United States Civil Rights Act of 1964 (as amended), Section 504 of the Federal Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) and Executive Orders 11246 and 11375 (Equal Employment Opportunity).

21. Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity
The Provider agrees to a written plan to address issues raised in the report including but not limited to access to services for racial and ethnic minority groups, and the provision of culturally competent services. In addition, the Provider agrees to fully participate in consultations and training events sponsored by the Board on this subject.

22. Liability
The Board assumes no liability for actions of the Provider or the Provider's employees under this Contract. The Provider agrees to hold the Board harmless against any and all liability, loss, damage, cost or expenses, including attorney's fees arising from acts or omissions of the Provider and/or its employees and/or subcontractors or from any violation of any of the state and federal laws and regulations, with which the Provider has certified he/she is in compliance. The Provider shall provide to the Board on an annual basis a certificate of liability insurance, as well as a certificate of professional malpractice insurance for any of its employees servicing this Contract who are required to have such insurance.

23. Miscellaneous

a. This Contract and the exhibits hereto contain all the terms and conditions agreed on by the parties and no other agreement regarding the subject matter of this contract shall vary the terms of this Contract unless in writing, signed by all of the parties.
b. The Provider will seek and receive the Board's written approval through an amendment before making significant programmatic or budgetary changes, utilizing the Contract Amendment form prepared by the Board.
c. The exhibits applicable to this Contract are incorporated herein by reference on page 1 of the Contract.
d. The Provider will cooperate with the Board in improving the system of care in Champaign County by participating in the Board's collaboration and networking efforts.
e. The Provider will cooperate with the Board in activities related to improvement and management of performance and attainment of desired outcomes associated with the services provided under this Contract.
f. The Provider's governing board must notify the Board of all Provider board meetings with the exception of executive sessions and provide the Board with copies of approved minutes of all open meetings of the Provider's governing board. The Provider will allow a Board liaison designated by the Board to attend the Provider board meetings and have access to the Provider's facilities.

24. Other Required Certifications
a. Drug Free Workplace – The Provider certifies that neither it or its employees shall engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of this Contract and that the Providers shall comply with all provisions of the Drug-Free Workplace Act (30 ILCS 580/1 – 580/11).
b. Bribery - The Provider certifies that he/she has not been barred from being awarded a contract or subcontract under Section 50-5 of the Illinois Procurement Code.
c. Bid-Rigging/Bid Rotating Law - The Provider certifies that he/she has not been barred from contracting with a unit of State or Local government as a result of a violation of 720 ILCS 5/33E-3 & 5/34E-4 of the Illinois Criminal Code of 1961.
d. Educational Loan – The Provider certifies that it is not barred from receiving State Agreements as a result of default on an educational loan (5 ILCS 385/1 – 385/3).
e. International Boycott – The Provider certifies that neither it nor any substantially owned affiliated company is participating or shall participate in an international boycott in violation of the provisions of the U.S. Export Administration Act of 1979 or the regulations of the U.S. Dept. of Commerce promulgated under the Act.

f. Charitable Trust – If the provider is a charitable organization subject to the Charitable Trust Act (760-ILCS 55/1), or the Solicitation for Charity Act (225 ILCS 460/1), the Provider certifies that all information required by the statutes referenced herein has been filed with the Illinois Attorney General.
g. Dues and Fees – The Provider certifies that it is not prohibited from selling goods or services to the State of Illinois because it pays dues or fees on behalf of its employees or agents, or subsidizes or otherwise reimburses them, for payment of their dues or fees to any club which unlawfully discriminates.
h. Felony Conviction – The Provider certifies that none of its employees who are servicing this Contract have been convicted of felonies in which the sentence from the said convictions has been completed less than one year before the execution of this Contract (30 ILCS 505/10/3).
i. Pro-Children Act – The Provider certifies that he/she is in compliance with the Pro-Children Act of 1994 (Public Law 103-227) in that it prohibits smoking in any portion of its facility used for the provision of health, day care, early childhood development services, education or library services to children under 18 which services are supported by Federal or State government assistance (except portions of the facilities which are used for inpatient substance abuse treatment).
j. Sexual Harassment – The Provider certifies that he/she will prohibit sexual harassment as defined by the Illinois Human Rights Act, 775 ILCS 5/2 – 101(E), and will not tolerate such conduct by its employees. Further, the Provider certifies that he/she has a written sexual harassment policy as required by the Illinois Human Rights Act (775 ILCS 5/2-105 (1994) and shall deliver to the Board a copy of such upon request.
k. Health Care – The Provider agrees to take necessary precautions to guard against contagious and communicable diseases including "Recommendations for Risk Reduction" from the U.S. Center for Disease Control.

25. Assignment

The Provider understands and agrees that this Contract, or any portion of this Contract, may not be sold, assigned, or transferred in any manner and that any actual or attempted sale, assignment, or transfer without the prior written approval of the Board shall render this Contract immediately null, void and of no further effect.

26. Authority to Execute and Bind

The persons executing this Contract on behalf of the Provider acknowledges that they have read and understand the terms herein and hereby warrants that they have the legal authority to execute this Contract and bind the Provider. The Provider's Board President specifically states that he or she has been granted such authority by resolution of the Provider's Board of Directors.

For the Champaign County Mental Health Board – Recommended by:

For the Provider

_____
Executive Director

_____
Executive Director / or CEO

_____
CCMHB President

_____
Board President

Pending Contracts
Awaiting Approval for Acting Administrator to Sign: November 2007

Between	For	Amount	CUPHD Division	Contract Period	Faxed to Fred
CUPHD and IDPH	Public Health services and related activities to benefit persons residing in the jurisdiction served by CUPHD.	$52,631.57	Administration	10-01-07 to 6-30-08	10-15-07
CUPHD (on behalf of the Champaign County Health Dept.) and IDPH	Public Health services and related activities to benefit persons residing in the jurisdiction served by CUPHD.	$52,631.57	Administration	10-01-07 to 6-30-08	10-15-07
CUPHD & IEMA	Indoor Radon Grant Program	$7,440	Environmental Health	10-01-07 to 9-30-10	11-02-07
CUPHD and IDPH	Emergency Preparedness (Amendment. Original grant for 30% of amount and year).	$118,999 (up from $26,420)	Environmental Health	End date 07-31-08	11-14-07
CUPHD (on behalf of Champaign County Health Department) and IDPH	Emergency Preparedness (Amendment. Original grant for 30% of amount and year).	$78,749 (up from $15,350)	Environmental Health	End date 07-31-08	11-14-07
CUPHD and Larry Rogers	Providing coordination services for the Young MSM Project	Payment for all services under contract not to exceed $70,500	Infectious Disease	11-01-07 to 06-30-08	E.mailed 11-16-07

Pending Contracts
Awaiting Approval for Acting Administrator to Sign: December 2007

Between	For	Amount	CUPHD Division	Contract Period	Faxed to Fred
CUPHD and IDPH	Housing Opportunities for People with AIDS (HOPWA). Rent and utility assistance for people with AIDS.	$99,114	Infectious Disease	01-31-08 to 12-31-08	11-20-07
CUPHD and IDPH	Death Certificate Surcharge Fund	$2,503	Vital Records	7/01/07 to 6/30/08	11-26-07
CUPHD and IDPH Office of Minority Health	Wellness on Wheels	$20,000	Infectious Disease	10/01/07 to 8/31/08	Email: 11-27-07

WHAT IS PUBLIC HEALTH?

According to the World Health Organization (1947) "health" is

> *"the state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity."*

Various physicians and other health practitioners in your community provide medical services to those who are already ill or infirm. Public health, on the other hand, focuses on prevention and education. Prevention, as the name suggests, is concerned with preventing disease rather than curing it. Prevention can be accomplished by reducing potential health hazards (such as cleaning up contaminated water), promoting childhood immunizations, conducting cancer screening programs, or offering smoking cessation classes. Health education that encourages individuals or groups to voluntarily adopt healthy behaviors plays an integral role in the prevention of disease.

Public health is an interdisciplinary field of practice that is populated by a variety of professionals: physicians, registered nurses, dentists, nutritionists, environmental specialists, health educators, social workers, epidemiologists, biostatisticians, laboratory specialists, and lawyers. No discipline dominates the field, however, since each is essential in diagnosing and treating a community.

Little is known about the earliest origins of public or community health. An account in Leviticus about 1500 B.C. probably represents the first written health code in the world. It dealt with a variety of personal and community responsibilities, including,

- cleanliness of the body,
- protection against the spread of contagious diseases,
- isolation of lepers,
- disinfection of dwellings after illness,
- sanitation of campsites,
- waste disposal,
- protection of water and food.

Beginning around 400 B.C., the Romans started to emphasize engineering techniques to provide safe water and to prevent disease. Some of the drainage systems installed then are still in use today in

Rome. During this period, a census was established, provision was made for safe disposal of garbage, building construction was regulated, and taverns and houses of prostitution were supervised.

From about 500 A.D. to 1500 A.D., often referred to as the Middle or Dark Ages, there was a strong reaction to science and reason and anything Roman, including sanitary codes. Little attention was paid to public health and prevention of disease. It was considered immoral to view one's own body; therefore people seldom bathed. Diets were poor and insufficient attention was paid to the preparation and preservation of food. As a result, the spread of disease was a common problem, and conditions such as leprosy and bubonic plague wiped out a large part of the world's population.

Leprosy spread from Egypt throughout all Europe, and gave rise to early immigration laws governing the movement and conduct of those affected. Lepers were compelled to warn others of their presence by crying out that they were "unclean." In many cases, they were declared legally dead and banished from communities. The result was isolation, which brought about rapid death. Although harsh, these measures almost eradicated leprosy in Europe by the 1500s.

Next came the bubonic plague or Black Death, as it was often called. From Asia, the plague spread across the Middle East, Egypt and Europe. During the 1340s, more than 13 million people died from the disease in China alone. Eventually, the plague was to claim 60 million lives, or half the world's population. In the late 1300s, Venice and other cities instituted the first quarantine measure in history when they began to restrict ships and travelers coming from infected regions to designated areas outside the port. Passengers had to remain free of disease for two months before the ship was permitted to enter the port. While the existence of quarantines indicates that the concept of disease incubation was understood during this period, people failed to recognize the role played by fleas and rats in carrying disease.

Following the Dark Ages came a renewed emphasis on science and reason. In 1837, England enacted sanitary legislation and established a national vaccination board. This was followed, in 1848, with the establishment of a general board of health. These measures were especially significant since such diseases as smallpox, cholera, typhoid and tuberculosis had reached epidemic levels. Out of one of these epidemics arose epidemiology. A London physician, Dr. John Snow, linked the high incidence of cholera in that city to a public well. He removed the pump handle and the incidence declined.

In colonial America, too, the threat of epidemic disease was very real. Smallpox was especially devastating to both natives and settlers. With so many people dying, the keeping of vital records became increasingly important. The first vital records legislation was enacted in 1639 by the Massachusetts colony, which ordered the recording of births and deaths. In 1701, laws were passed to isolate smallpox patients and quarantine ships when necessary. In 1799, the first board of health was formed in Boston with Paul Revere as its chairman. Paul Revere, among other professions, was a dentist.

Between 1800 and 1850 many epidemics--smallpox, yellow fever, cholera, typhoid and typhus--swept over the United States. The death rate from tuberculosis in Massachusetts in 1850 reached 300 per 100,000 people.

In 1859, a report by the Sanitary Commission of Massachusetts, titled the Shattuck Report, called for the establishment of state and local boards of health. This report included the major concepts and activities of today's public health departments and led to boards of health being established all across the country.

During the last half of the 19th century and the first half of the 20th century, public health struggled against infectious diseases. Strategies included major sanitation measures, the development of effective vaccines, and mass immunization. Efforts were so successful that today only 1 percent of the people who die before age 75 in the United States die from infectious diseases.

The leading causes of death in 1900 were influenza, pneumonia, diphtheria, tuberculosis, and gastrointestinal infections. These acute diseases accounted for a death rate of 580 of every 100,000 people. Today, only 30 people per 100,000 die from these diseases each year. These gains were not achieved so much through treatment and curative medicine as through improved sanitation, better nutrition, the pasteurization of milk, and the control of infectious diseases.

Public health today faces different challenges. Along with the decline in major acute infectious diseases between 1900 and 1970, came a growing number of deaths from major chronic diseases, such as heart disease, cancer and stroke, which increased by more than 25 percent. Cardio-vascular disease now accounts for about one-half of all deaths. Cancer is responsible for another 20 percent and injuries account for a large number of deaths. We also have new diseases, like AIDS, for which effective methods of prevention and treatment do not yet exist.

The efforts of public health workers must be aimed at these killers and cripplers. We must concern ourselves with motivating people to make changes in their lifestyles. We must create incentives for people to change their health behavior, and we must sustain and support those lifestyle changes. As a local health board member, it becomes your responsibility to create the conditions in your community that are most conducive to maintaining and improving its residents' health.

Adapted from "A Guide for Local Board of Health Members in Indiana" (1996) and House, R. "Assess, Address, and Assure: Manual for North Carolina Local Boards of Health" (1993).

CORE FUNCTIONS, ORGANIZATIONAL PRACTICES and ESSENTIAL SERVICES

This section contains the core functions of public health and the 10 public health organizational practices and 10 essential services that support them.

Three Core Functions of Government in Public Health

The Institute of Medicine report, *The Future of Public Health,* extensively discussed the three core functions of government in public health:

(1) Needs assessment
(2) Policy development
(3) Assurance

These three functions relate to the critical activities of problem solving in the public health field. The major phases of problem solving include the identification of problems, the mobilization of necessary effort and resources and, finally, the assurance that vital conditions are in place and that critical services are provided.

Needs assessment involves all activities related to community diagnosis: surveillance, identification of needs, analysis of the causes of problems, collection and interpretation of data, case-finding, monitoring and forecasting trends, research, and the evaluation of outcomes. Adequate funding for this activity is a constant problem. However, the activity is critical to sound planning activities.

Policy development is a complex process that fosters interaction and consensus among a wide range of public and private organizations and individuals. It is through policy that society makes decisions about problems, chooses goals and the proper means to reach them, handles conflicting points of view about ways to address problems and, finally, allocates resources. Government provides guidance in this process.

Assurance relates to implementing legislative mandates and maintaining statutory responsibility. It is critical that mechanisms be in place to guarantee that necessary services are provided to meet agreed upon goals. Assurance include regulation of services and products provided in both the public and

private sectors, accountability to people setting health objectives and providing reports on progress, and developing adequate responses to health crises. The assurance function requires the exercise of authority. It also provides the guarantee for certain health services.

Source: University of Illinois at Chicago, Illinois Public Health Leadership Institute, December 1992.

The 10 Public Health Organizational Practices

Efforts have been made, particularly since the late 1980s, to refine the role of government within the public health system. In 1988, the Institute of Medicine report, *The Future of Public Health,* stressed the role of governmental public health agencies in terms of three core functions: needs assessment, policy development, and assurance. In 1989, the U.S. Centers for Disease Control and Prevention initiated a process to identify core organizational practices necessary for governmental agencies to carry on the public health mission. In an effort involving representatives from governmental public health agencies and related associations, both at the practice and academic level, 10 organizational practices were identified. Therefore, while needs assessment, policy development and assurance can be viewed as broad functional dimensions; the 10 practice standards provide an operational definition of the public health core functions.

The **10 organizational practices,** that define the role of local public health agencies in carrying out their mission, are:

- **Assess the health needs of the community** by establishing a systematic needs assessment process that periodically provides the agency with information on the health status and health needs of the community.
- **Investigate the occurrence of health effects and health hazards in the community** by conducting timely epidemiologic investigations that identify the magnitude of health problems, duration, trends, locations, and populations at risk.
- **Analyze the determinants of identified health needs** in order to identify etiologic and contributing factors that place certain segments of the population at risk for adverse health outcomes.
- **Advocate for public health, build constituencies, and identify resources in the community** by generating supportive and collaborative relationships with public and private agencies and constituent groups for the effective planning, implementation and management of public health activities.

- **Set priorities among health needs** based on the size and seriousness of the problems, and the acceptability, economic feasibility, and effectiveness of interventions.
- **Develop plans and policies to address priority health needs** by establishing goals and objectives to be achieved within a systematic course of action that focus on local community needs and equitable distribution of resources and that involve the participation of constituents and other related governmental agencies.
- **Manage resources and develop organizational structure** through the acquisition, allocation and control of human, physical and fiscal resources and maximize the operational functions of the local public health system through coordination of community agencies' efforts and avoidance of duplication of services.
- **Implement programs** by taking actions that translate plans and policies into services.
- **Evaluate programs and provide quality assurance** in accordance with applicable professional and regulatory standards to ensure that programs are consistent with plans and policies, and provide the agency with feedback on inadequacies and changes needed to redirect programs and resources.
- **Inform and educate the public** on public health issues of concern in the community, and promote awareness of available public health services and health education initiatives that contribute to individual and collective changes in health knowledge, attitudes, and practices.

Source: University of Illinois at Chicago, Illinois Public Health Leadership Institute, February, 1993.

The 10 Essential Public Health Services

Public health serves communities and individuals within them by providing an array of essential services. Local health departments and agencies work with communities to achieve these essential services.

The chart that follows highlights the 10 essential services of public health. All public health responsibilities (whether conducted by the local public health agency or another organization within the community) can be categorized into one of the services.

PUBLIC HEALTH IN AMERICA

Vision:

Healthy People in Healthy Communities

Mission:

Promote Physical and Mental Health and Prevent Disease, Injury, and Disability

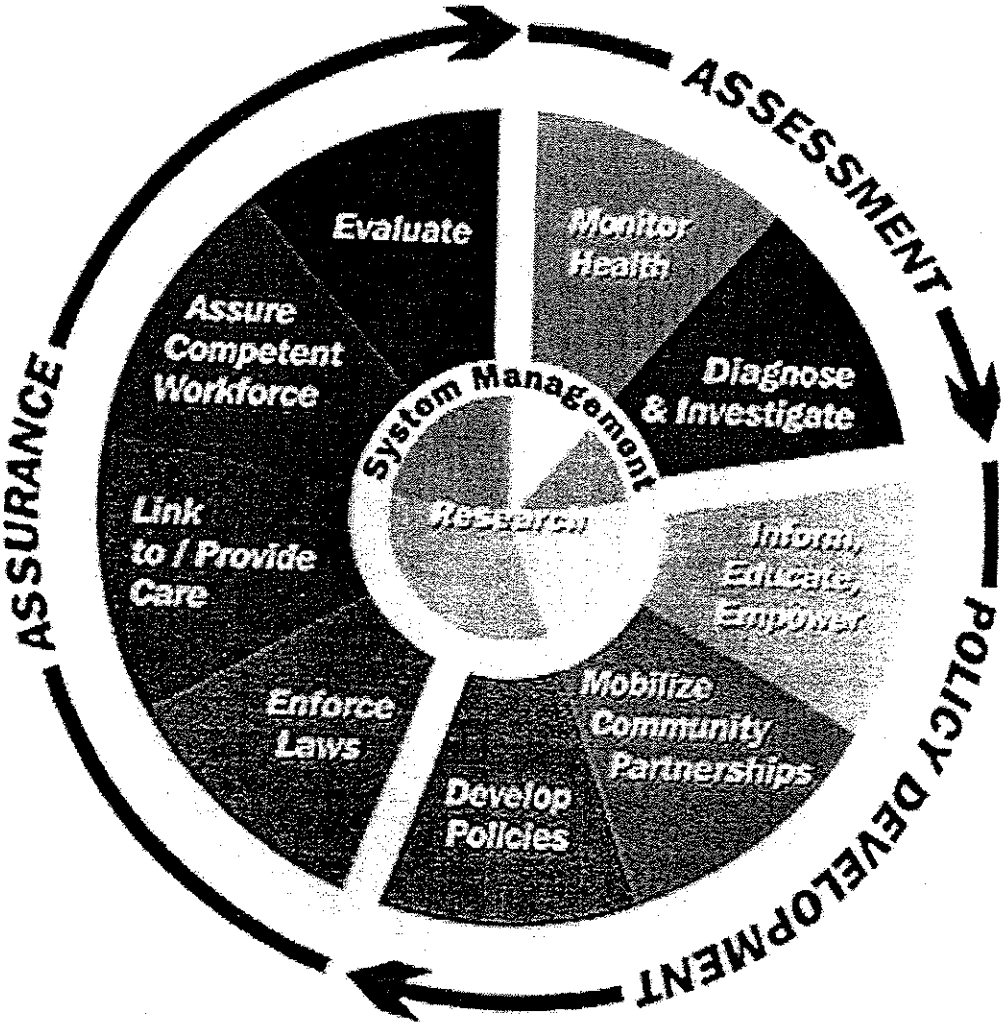
Public Health

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

On the web at http://web.health.gov/phfunctions/public.htm


ASSESSMENT
POLICY DEVELOPMENT
ASSURANCE
Monitor Health
Diagnose & Investigate
Inform, Educate, Empower
Mobilize Community Partnerships
Develop Policies
Enforce Laws
Link to / Provide Care
Assure Competent Workforce
Evaluate
System Management
Research

FUNCTIONS OF BOARDS AND BOARD MEMBERS

Boards are faced with a dilemma: On one hand, a board of health is responsible for the public's health and a local public health department; on the other hand, popular sentiment sometimes tells the board to stay out of administration and not to interfere. How is a board of health to meet its responsibilities if it does not interfere at least some of the time? Some boards choose to meddle anyway. Others take such a hands-off approach that the local administrator must guess the board's values and directions. Consider how hard it is for a local administrator to decide on a course of action, only to discover later that his or her actions were unacceptable. Still other boards set policies that guide administrators toward board goals but leave the methods (within stated limits) to the individual administrator. Boards that choose the latter approach are able to uphold their immense responsibility in an equitable fashion by being fair to both the administrator and the community.

Policy-making versus Operations

Boards get entangled in staff activities in a variety of ways. For example, staff may bring things to the board because no guidelines exist for making a decision that the board will accept. Board members ask for staff reports and may attend staff level meetings. Some boards find themselves enmeshed in an issue due to a member's curiosity or expertise. No matter how important any of these situations are or may seem, they are staff level work. While decisions in these situations may serve the organization, they do not guide it. It must be remembered--boards of health are responsible for policy issues, not operational issues.

Boards should focus their interest on the effectiveness of staff work. Do staff activities achieve the board's goals? The best way for a board to achieve results is by intentionally not looking at day-to-day operations but rather at achieving it goals in a lawful, ethical and prudent manner.

When staff work requires board approval for legitimacy, the staff is not empowered. The board must free itself from staff decisions by explicitly detailing everything it could never approve and thereby implicitly approving all other staff actions. Where there is security for the board and flexibility for the administrator, everybody wins.

Who is Responsible?

AREA	BOARD OF HEALTH (Policy)	ADMINISTRATOR (Operations)
Long-term goals (taking more than one year)	Approves	Recommends and provides input
Short-term goals (taking one year or less)	Monitors	Establishes and carries out
Annual report and plan	Approves	Assesses, develops and carries out
News media releases	Adopts policy; supports public health position	Approves all media releases
Day-to-day operations	No role	Makes all management decisions
Budget	Approves	Develops and recommends
Capital purchases	Approves	Prepares requests
Decisions on building renovation, leasing, expansion, etc.	Make decisions; assumes responsibility	Recommends; signs contracts after board approval
Purchases of supplies	Establishes policy and budget for supplies	Purchases according to board policy; maintains an adequate audit trail
Major repairs	Approves	Obtains estimates and prepares recommendations
Minor repairs	Establishes policy, including amount that can be spent without board approval	Authorizes repairs up to predetermined amount

AREA	BOARD OF HEALTH (Policy)	ADMINISTRATOR (Operations)
Emergency repairs	Works with administrator	Notifies board chairperson and acts with concurrence from chair
Cleaning and maintenance	No role (oversight only)	Sets up schedule
Fees	Adopts policy	Develops and sets fee schedules
Billing, credit and collections	Adopts policy	Proposes policy and implements
Hiring of staff	Hires administrator only	Approves hiring of all subordinate staff
Staff development and assignment	No role	Establishes
Firing of staff	Fires administrator only	Approves firing of all subordinate staff
Staff grievances	Establishes a grievance committee	Follows grievance procedures
Personnel policies	Adopts	Recommends and administers
Staff salaries	Allocates budget line item for salaries; approves yearly percentage increase	Approves salaries with recommendations from supervisory staff
Staff evaluations	Evaluates administrator only	Evaluates supervisory staff

Responsibilities of Board Members

These expectations may be adapted to reflect your board's actual expectations of its members. Your board can adopt any of these and add others as needed. What is important here is that all board members know what is expected of them.

Specific expectations of board of health members:

Assess

- Educate yourself on your community and its public health status. As a county resident, you are in an excellent position to know your community's problems and needs.
- Educate yourself on your board and local department's history, goals, achievements, and current situation.

Develop Policy

- Establish bylaws for the board of health (see example in Appendix B).
- Attend board meetings regularly and promptly.
- Review all meeting materials in advance of meeting.
- Do assigned work between meetings.
- Participate fully in open, constructive dialogue regarding local public health both in and out of meetings.
- Ask critical questions; seek clarity and implications of decisions before voting.
- Function as a policy-maker not as an administrator.
- Link the community and the local health department.
- Represent a broad cross-section of the community to the board.
- Represent public health to the community.
- Speak for the board only when delegated to do so.
- Actively participate in political activities at local, state, and national level concerning local public health.

Assure

- Keep decision-making at the primary and secondary policy levels.
- Stand behind decisions of the board and its director.
- Inform the community of public health financial backing.
- Anticipate trends likely to affect the local health department.

Evaluation

For evaluation to be effective it must be formalized. The board and the local administrator need to agree on how and when each will be evaluated. The board needs to define what it does and what responsibilities it delegates to the administrator. Until the board clearly defines its own role, it will be unable to evaluate the local administrator fairly.

Board Evaluation

Boards need to rate their own performance. Did the board set a long-range work plan? How well did it do in accomplishing its objectives? What did the board do that was not listed as a target? What remains to be done? What is the new work plan?

Boards should also assess the meeting evaluations from the past year. What are common problems? Where has improvement been made? What goals should be set for next year?

How long should a person serve on a local board of health? Board members need to address this question; each board must find its own answer. Individually, members should ask themselves certain simple, but searching, questions about their continued involvement:

1. Am I still interested?
2. Do I participate actively and responsibly in board matters?
3. Do I attend the regularly scheduled board meetings?
4. Do I have confidence in the board, the administrator, and the health department staff?
5. Is my service on the board at least as satisfying and rewarding as any other service to which I might devote similar time and effort?

Boards, as a whole, need to consider how length of tenure influences board effectiveness.

Administrator Evaluation

The administrator's job is to make the board's policies come live. Therefore, evaluating the administrator is also evaluating the local department and the state of public health in your county or district. The board hires the administrator to run the department and to achieve public health goals. While the board should be clear about what results it wants to see in the community, it should not direct the administrator's day-to-day management of the local department.

The board of health should annually review the health department administrator's performance. The board should evaluate its administrator just as a supervisor does with an employee. Supervisors measure and communicate actual performance based on planned expectations; they pay for the value of the employee and provide a framework for the professional development of the employee. Boards that use evaluation as a precursor to firing are not working to improve an employee's ability to do the job. Evaluation of an employee should be a regular part of staff development, regardless of an organization's size.

Performance-based evaluation is an excellent way for boards to evaluate an administrator and to evaluate themselves. Such evaluations allow individuals and organizations to see how well responsibilities are being fulfilled. The board should look at each statement in the job description and indicate how the administrator fulfills that expectation. It is unfair to judge or rate an administrator on things that are not included in his or her job description. (The same goes for the board when it is evaluating itself.) Additionally, the board needs to state clearly its standard of performance for each evaluation item. A review of this type may reveal that job descriptions need to be created or updated.

Compare the administrator's job description and work plan to his or her accomplishments. Stick to the direct evidence and be clear about what is to be evaluated. If the board, in the absence of policy prohibiting such activities, disapproves of certain methods used to complete a task, the board has identified a policy need, not an administrator failing. Boards must look at outcomes of staff work, not at how staff does its work.

If your county requires a standard evaluation that is not performance based, consider also evaluating your administrator by the performance method. Standardized forms are appropriate for most evaluation situations but may be inadequate or inappropriate for a board's evaluation of its administrator. Standard forms must be general enough to apply to many positions, so they may omit important or specific aspects of more complex positions.

Several things are important to stress in evaluation:

- The evaluation must correlate to the actual job.
- Specific definitions of "Superior," "Average," "Acceptable," etc., must be agreed on before the evaluation.
- Schedule the evaluation activities into the board agenda over the year.

- Summarize the evaluation in writing and provide an opportunity for the director to record his or her comments.
- Stick to job performance, not personal characteristics.

Additional responsibilities of a president or chairperson of a board of health:

- Chair all meetings.
- Facilitate discussion and decision-making.
- Work with administrator to set agenda for meetings.
- Counsel and consult with the administrator.
- Speak for the board as delegated by the board.
- Represent the board to other groups.
- Consult with board members who are not fulfilling their responsibilities or who are violating law, policy or practice.
- Initiate annual evaluation of the administrator.
- Initiate annual evaluation of the board.

The president or chairperson of the board must exhibit leadership ability and provide direction to the administrator and the health department staff. How long the chairperson should serve, is best decided by the board itself. When selecting a chairperson, the board needs to look for someone who is active and concerned with the issues of the health department. The chairperson may be called on to go to county governing bodies to support health department concerns and issues. The person selected for this leadership position should be someone who has the time, energy, and savvy to work within county government to represent the concerns of the board and the health department.

Public Health Practitioner Certification Program

In an effort to ensure the competency of local health administrators, the Public Health Practitioner Certification Board (PHPCB) offers an independent certification program for Public Health Administrators. Such certification may assist local boards of health in recruiting, hiring and promoting competent local health professionals. If you would like more information about the certification program, please refer to **Appendix D** and visit PHPCB's website at www.phpcb.org.

Tips on Being a Good Board Member

Some basic tips on ways to be a good board of health member are listed below:

- *Work cooperatively with your administrator. Rely on his/her technical expertise and do not duplicate his/her efforts.*
- *Do not assume that your health board or health department can instantly solve all problems. Proper enforcement procedures do take time. Identify priorities and coordinate resources at all levels.*
- *Be willing to take a stand on important health issues, even if it means disagreeing with the governmental body that appointed you.*
- *Learn to make necessary decisions, even in the midst of adverse public reaction.*
- *Know the difference between private problems and those that actually have impact on the public.*
- *Seek out information from all possible sources before making important decisions.*
- *Do your homework: read pertinent reports, memos and budgets before board meetings.*
- *Volunteer for appropriate local health department service programs; it gives you valuable firsthand insight into the programs you are sponsoring and provides valuable assistance to the local department as well.*
- *Communicate frequently with your administrator and with representatives of your governing body. Consider appointing a liaison to attend other agency/governmental meetings. You can make valuable allies, as well as find out important information ahead of time.*
- *Be a health proponent in your community. Promote your health board and your health department.*
- *Do not make promises to constituents without real knowledge of the health board's or health department's ability to keep them.*

- *Codes on many issues are available from the Illinois Department of Public Health and other governmental agencies. Do not write an ordinance unless you have the resources to conduct the program envisioned.*
- *Know that your local states attorney will give legal advice on your rights and responsibilities.*
- *Take an active role in planning and zoning issues; you may be able to stop potential problems before they start.*
- *At all times, even in times of crisis, the administrator (or appointed staff) should serve as the liaison to the media, not a member of the health board. The health department staff will have the latest information and will have the best grasp of any technical information that must be translated for the public.*
- *Your role as a private citizen setting local health policy is important to your community.*
- *Make sure the board complies with the Illinois Open Meetings Act (see Appendix C).*
- *Enjoy your work and remember you are essential in providing public health services to your community.*

Adapted: Associations of North Carolina Boards of Health and Indiana Boards of Health

CHAMPAIGN COUNTY BOARD OF HEALTH

Brookens Administrative Center
1776 E. Washington
Urbana, IL 61802

Phone: (217) 384-3776
Fax: (217) 384-3896

Champaign County Board of Health

Tuesday, November 27, 2007
6:00 p.m.
Brookens Administrative Center, 1776 E. Washington
Meeting Room 3
Urbana, Illinois
PLEASE NOTED THE CHANGE IN ROOM LOCATION

ADDENDUM

ITEM **PAGE NO.**

J. Finance

3. Invoice submitted by CUPHD for October 2007

The mission of the Champaign County Public Health Department is to promote health, prevent disease and lessen the impact of illness through the effective use of community resources.