CHAMPAIGN COUNTY BOARD OF HEALTH

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Champaign County Board of Health

Tuesday, June 23, 2009
6:00 p.m.
Jennifer K. Putman Meeting Room
Brookens Administrative Center, 1776 E. Washington
Urbana, Illinois

AGENDA

c. Environmental Health (Peterson)
d. Wellness & Health Promotion (Ramirez)

J. Issues Regarding Smile Healthy (Kassem)

1. Monthly Report
2. Smile Healthy (formerly CIDES) Audited Financial Statements for the Year Ended December 31, 2008 *(Provided for Information Only)*

K. Other Business

1. Public Health in Peril: The Call to Action 58-67
2. NALBOH Welcome Packet

L. Public Participation on Non-Agenda Items Only

M. Adjournment

CHAMPAIGN COUNTY BOARD OF HEALTH

Monthly Meeting
Tuesday, May 26, 2009, 6:00 p.m.

Call to Order & Roll Call

The Board of Health held its monthly meeting on May 26, 2009 in the Jennifer K. Putman Meeting Room at the Brookens Administrative Center, 1776 East Washington, Urbana. The meeting was called to order at 6:00 p.m. by Julian Rappaport. Board members Prashanth Gowda, Stan James, Nezar Kassem, John Peterson, Cherryl Ramirez, Julian Rappaport, Bobbi Scholze, and Betty Segal and were present at the time of roll call. Board member Brenda Anderson was absent. The staff members present were Kat Bork (Board of Health Secretary) and Susan McGrath (Senior Assistant State's Attorney). Also present were Deb Busey (County Administrator of Finance & HR Management), Nancy Greenwalt (Smile Healthy Executive Director), Julie Pryde (CUPHD Administrator), Andrea Wallace (CUPHD Finance Director), and C. Pius Weibel (County Board Chair & CUPHD Board Member).

Approval of Agenda/Addendum

Rappaport suggested considering all CUPHD and Smile Healthy agenda items at the same time as the agencies' budget requests so all related items are discussed together

MOTION by James to approve the agenda as amended; seconded by Kassem. **Motion carried.**

Approval of Minutes

MOTION by James to approve the Board of Health April 28, 2009 minutes; seconded by Kassem.

James asked for "stating" on Line 93 to be changed to "starting." Rappaport asked for the correct date to be listed on the first line.

Motion carried as amended.

MOTION by Peterson to approve the Board of Health March 31, 2009 minutes; seconded by Kassem. **Motion carried.**

Public Participation on Agenda Items Only

There was no public participation.

Correspondence and Communications

There was no correspondence or communications.

Treasurer's Report

Distribution of Public Health Levy for FY2009

Peterson asked if Busey had anything to add to the memo included in the agenda packet that she prepared regarding the public health levy distribution for FY2009. Busey remarked that the property tax revenue is always an estimate until she receives the final certification of the tax extension in late March from the County Clerk and the final distribution of the EAV within and outside CUPHD. The percentage changed in CUPHD's favor. CUPHD will receive more than budgeted and the BOH will receive less than budgeted because the percentage of value within CUPHD is greater than it was last year. It applies to the current fiscal year. Busey does not think it will require a budget amendment this year.

Approval of CUPHD Invoice for March 2009

Peterson stated the March invoice was consistent with the contract budget.

MOTION by Peterson to approve payment of the CUPHD invoice for March 2009; seconded by Kassem. **Motion carried.**

Budget Requests for FY2010 Funding

CUPHD – Presentation

Pryde updated the BOH that the H1N1 flu is spreading. There are still no cases in Champaign County. This is not our flu season, so it may hit us in the fall. The worst case scenario would be for flu to mutate and the best case scenario would be that it comes back as seasonal flu. Peterson inquired about the vaccine situation. Pryde stated no decision has been reached yet on the vaccine. The vaccine may take two shots and she heard from IDPH that any vaccine will be released slowly to prioritized groups first such as children, people with underlying health conditions like pregnancy, and healthcare providers. Peterson was amazed at how many health care providers do not get a flu shot and Pryde concurred because H1N1 has spread throughout the world. Gowda report the website **www.pandemicflu.gov** gives useful updates on all type of flu. Pryde noted that website is linked to the CUPHD website and updates can be viewed on the Champaign County Prepares website.

Wallace distributed the CUPHD budget documents and stated they were the same documents she distributed at the study session held earlier in May. Wallace wanted to review the document she emailed to the BOH last week about services provided to County residents. She went through CUPHD's 2008 Annual Report and indicted whether the CUPHD programs are paid for by the BOH and included in the FY2010 budget. She calculated 27% of CUPHD's services are specifically benefiting County residents. Pryde said there seemed to be some confusion that the only services County residents receive come through the BOH core services and that is not true because CUPHD receives grants that cover wider jurisdictions than just CUPHD. She stated lots of services were provided to County residents through all kinds of different funding. Wallace said some grants are 100% funded, while others are funded by a combination of grants, fees, and property tax revenue. Wallace said she broken down the services between the core services, grants, and purchased services. The purchased services are

items CUPHD covers that can be grant-based or are available to be purchased by the BOH. She listed the Illinois Breast & Cervical Cancer Program and the mobile program as examples of purchased services.

James asked about the legal opinion McGrath was going to provide concerning the core services. McGrath promised the Board would have the opinion for the June meeting.

Segal asked about "I" under the status on CUPHD's document. Wallace explained the "I" meant the services were currently included in the County contract and the BOH was paying for them. Wallace stated the STDs are not included and Pryde clarified that CUPHD provides the service to County clients but the BOH is not paying for it. Wallace said CUPHD is currently subsidizing those programs and the description in the FY2010 proposed budget would match this. Pryde said that was being done because CUPHD was trying to get the division in shape. Segal said the BOH has wanted to know what services it is paying for versus what services it was receiving and thanked Wallace for the information.

Turning to the FY2010 contract proposal, Wallace stated the only change from the document she distributed two weeks ago was the Environmental Health fee revenue. Wallace prepared the FY2010 proposal with subtotals by grants and core services with other services that could be purchased. There is a total of $97,199 in grant revenue for FY2010. This is a decrease of $16,714 from the FY2009 grant funding. The grant revenue is estimated from year to year because CUPHD does not know how the grants will be funded. The figures are based on the current state fiscal year contracts that end in June 2009. Rappaport asked if the state grants were for the whole of Champaign County, including Champaign-Urbana. Wallace said these are grants are specific to the County and CUPHD has separate grants that cover the same things. Rappaport asked if the grant funding was handled as pass-through funds. Wallace stated CUPHD spends the funds upfront and then asks for reimbursement from the state. She detailed the proposed core services cost as $606,567. The BOH is currently paying $407,270 for core services, so the increase in FY2010 amounts to almost $200,000. Wallace explained the two yellow columns on her spreadsheet were the Infectious Disease Control and Vital Statistics core services. These are core services not included in the FY2009 contract and 100% of costs are covered by CUPHD at this time. She drew the Board's attention to Page 9, which showed what is included in Infectious Disease Control. Infectious Disease Control includes communicable disease investigation, hepatitis, STDs, and tuberculosis. There are four active TB cases in the County and all are compliant. A noncompliant TB case can cost $25,000 to isolate and treat the individual. Wallace advised the BOH to consider these potential costs when they are preparing a budget and to set aside funds for unexpected incidents. The total FY2010 CUPHD proposal is $703,766, about a 35% increase over the FY2009 budget. The back page of Wallace's document listed additional services that the BOH could purchase separately, such as the mobile programming, IBCCP, and clinical services. These are programs funded outside of what is covered by the grant that are additional costs to the BOH. Wallace stated the vision and hearing costs are pretty much covered with a grant, Medicaid, or client fees. The Vision Cooperative is a program CUPHD runs solely funded from Medicaid fees and is subsidized by property tax dollars in the amount of $12,326. Wallace estimated 18% of those clients are County residents, which is billed to the BOH. The well water testing offered by CUPHD and is outside of the core service. CUPHD tests residents' wells as requested and charges a $20 fee. The fee does not

cover the cost of providing this service, a majority of which is personnel-related. Well water tearing is 100% County residents and Wallace estimated the program costs $9,606 to subsidize. Pryde said County residents have called asking CUPHD to perform lead testing of their soil. CUPHD has the equipment and certified staff to perform this service, but they have never done it. The BOH would have to set a fee if this service was offered. James thought the BOH was not required by law to offer well water and soil testing. Pryde concurred it was absolutely not required by law. Pryde recommended the BOH consider whether its wants to offer flu shots for County residents. Flu shots have been the most used service on the mobile unit and this service would stop if the mobile funding is discontinued. If the BOH wanted to offer flu shots clinics in the County, they will have to make plans and add those expenses to the FY2010 budget. Wallace summarized that the total CUPHD FY2010 contract proposal was $803,050. The entire FY2009 contract budget was $660,589, making FY2010 an increase of 21.5% if the BOH accepts everything in the proposal.

James noticed the some of the increased cost of Vital Statistics is related to the state no longer providing the paper free-of-charge. Wallace confirmed that CUPHD used to get the death and birth certificate paper for free and this has stopped. The security paper is very expensive and is a new cost.

Segal asked about the Infectious Disease services that Wallace indicated the BOH has not been paying for, although the mobile unit funded by the BOH does address infectious disease. Wallace said those were two totally different services. Pryde said Infectious Disease is more than the communicable disease services. The mobile unit provided flu shots, STD-related services, and IBCCP referrals. Pryde stated that CUPHD's finances were a mess when she first came on and she decided to hold off on Infectious Disease until she knew what was going on with it. This is why the BOH has not been paying for Infectious Disease.

Scholze inquired about the cost per unit served of the stop smoking programs. It appeared $26,000 was spent to serve 226 people. Pryde said that money has to be spent on it because the grant was very specific. Wallace said those numbers were not necessarily the clients served and suggested looking through CUPHD's annual report for more information.

Busey asked about what services the IDPH grant covered as described in the CUPHD FY2010 contract proposal. Wallace said Number 7 is specific to IBCCP when it talks about IDPH grants. The IBCCP Program alone receives $662,000 from IDPH. Busey asked if the County receives a portion of that funding. Wallace answered no. CUPHD receives all the IBCCP funds and it is not limited to where they provide the services because CUPHD administers the funds for three counties. Busey wanted to understand the grants so they correctly listed in the County budget report. She asked what services CUPHD accounted for with the BOH's IDPH Health Protection Grant. Pryde answered core services. Busey inquired what amount the IDPH Health Protection Grant would be in FY2010 so the BOH could properly budget for it. Pryde said Carol Wadleigh received the grants. Busey asked if the IDPH Health Protection Grant was supposed to cover core services. Pryde said the grant was intended to be applied to core services, but never covers those costs. Busey asked if it could be applied to any core service. Pryde said the grant could be applied to any core service or other things, but her understanding was that it should be applied to core services.

Rappaport acknowledged it was difficult to follow the CUPHD contract proposal and asked if the BOH's cost for core services were the yellow columns. Wallace said the subtotal of core services was $606,567 and was in Column B. The yellow columns depict what is not currently funded. Rappaport asked if the reason for the increased cost to core services in FY2010 was because CUPHD was not charging the BOH. Pryde said CUPHD was just not charging the BOH because there was a mess with CUPHD finances when she took over as Administrator. She said the BOH had been basically getting its Infectious Disease and Vital Statistics services for free until CUPHD sorted out what its previous Finance Director had done. Pryde was tried to give the BOH the benefit of the doubt. She stated the FY2010 proposal is the numbers with client data and real costs. She does not know what the previous CUPHD Finance Director was doing. Rappaport asked what actual services the BOH would receive for $606,567. Wallace answered the services were food establishments, water program, sewage program, communicable disease, hepatitis integration, STD, and tuberculosis. Wallace said the bottom line is there will be services CUPHD provides that the BOH will not be able to provide due to resources. Rappaport wanted to understand how the services add up to $606,567. Wallace explained they would not get that from document listing the services. The list of services gives a description that corresponds to the budget. The first three services listed are Environmental Health services on the budget document. Discussion continued over how to correlate the numbers of services with the budget. Peterson suggested it might be helpful if Wallace added a column correlating the budget with the services. Wallace suggested BOH look at CUPHD's annual report. The BOH discussed how to calculate the cost per visit of core services. Wallace said the majority of costs are personnel-related. James was amazed at number of restaurants that were inspected. Rappaport's aim was to ensure all Board members understood what they were paying for in the budget and how that relates to the BOH's income.

Peterson said the IMRF cost is a policy question made by CUPHD which is in variance with the County. He asked how the FY2010 CUPHD proposal would be affected if the IMRF costs were put in line with the County's policy. Wallace said she did not figure this. She was instructed to put in the full 11.3% going forward. Busey stated one entity cannot adopt two different IMRF rates and the CUPHD Board determines the IMRF rate for the district. Wallace said the IMRF rate has not yet been adopted by CUPHD Board. Busey asked if Wallace knew the difference in total cost impact on the entire organization between the full rate and the phase-in rate. Wallace did not have that information.

Busey asked if Wallace could add two columns for County's costs and CUPHD costs on the services list. She thought the BOH was looking for a way to put the dollar costs with the number of services on one document. Busey asked about the IBCCP Program and whether it was mandatory for the County to pay for services beyond what the grant provides. Wallace said the IBCCP Program grant required a match and the BOH was billed for its portion of the matching funds. Peterson noted IBCCP was not included in the annual report three-four years ago, so the BOH started looking at it more closely. CUPHD administers the IBCCP Program for a consortium of three counties: Champaign, McLean, and Vermilion. McLean County and Vermilion County stop providing services when the grant allocation ends. Champaign County keeps providing IBCCP services for the remainder of the fiscal year after the grant money runs out. Peterson said three years ago that it would be politically difficult for Champaign County to not to provide those services, but he also said CUPHD should be going after McLean and

Vermillion Counties to come up with their share. Now that CUPHD is getting its administrative house in order, CUPHD could address this issue with McLean County and women's groups. Pryde spoke to McLean County's public health department, but they will not open easily open their wallets. She reported the state poured in resources into IBCCP and is now pulling the resources right back. She is not sure what will happen with this program. Pryde thought it would be easier to get money from McLean and Vermillion now that a lot more clients are enrolled in IBCCP.

Rappaport said the BOH needs to understand exactly what it is being asked to pay for and what it buys. The BOH needs to get a legal opinion about what it absolutely must provide, which will be provided at the next meeting. From that point and given the amount of resources, the BOH will have to determine what it can spend. The BOH cannot continue the programs it has with this budget change from CUPHD. He emphasized that the BOH was not making any decisions at this moment and encouraged members to ask questions if any budget requests are unclear.

Pryde said her understanding of the Local Health Protection Grant and how core service works was that a public health department has to have an Administrator, provide certain services, and do a local assessment of needs every five years in order to exist as a public health department. A public health department who does not do these things can no longer receive a Local Health Protection Grant or levy taxes. McGrath agreed and stated the question the Board has asked her to address is what the state actually requires they provide within those parameters. The Board wants to know the standard by which the state measures a health department's performance. James asked McGrath what the BOH is required to do if the grants do not cover the cost of providing the core services. In his mind, if state grant does not cover the program cost then they cannot operate the program. Pryde said the difference is the BOH has the ability to levy taxes to get extra money to run the programs. McGrath said the problem with food establishments that is being discussed is no fees are collected for enforcement and this is the reason for the big gap between the fees revenue and cost of the program. Rappaport and Peterson were under the impression that enforcement fees collection would not amount to that much money, based on what CUPHD Environmental Health Director Jim Roberts has said. McGrath said the enforcement fees would not cover everything, buy they could be collecting some revenue, which is better than zero. If enforcement fees were added to the ordinance, they could be collected.

Rappaport asked about the difference between the costs of core service administration and the actual core services. Wallace said Page 7 shows the personnel that go into supporting all of the County programs outside of the employees actually performing the core services. Administration included the cost of the CUPHD Administrator, finance staff, different division directors, support staff, computer staff, and marketing staff. Rappaport asked if those were indirect costs. Wallace said part of it was indirect costs. The administration expense to the BOH increased substantially because CUPHD changed the number of employees and percentages of their time charged to the County. Rappaport did not understand how the BOH was charged for administration of service it was not being charged for. Pryde said it is staff who are there regardless and lots of costs are associated with staff. Peterson indicated the budgeting process up to now has been a bit of smoke and mirrors. Pryde agreed and stated they are trying to make it

real. The BOH was not paying for communicable disease and part of her job is to make the sure all the services in the County are sustainable. Rappaport was not intending to suggest CUPHD was trying to do anything wrong; it is responsibility of the BOH to understand the budget it approves and to know what the dollars are for. Therefore, it is responsibility of the staff and administration to explain their budget proposal so the BOH can vote on it in good faith. Pryde said CUPHD was providing it to the BOH and doing as much as they possibly can. She said the CUPHD contract proposal may or may not be meaningful to the BOH regardless of what columns are added. She emphasized CUPHD staff has been to every meeting and spent hours on this budget. Rappaport reiterated that he was not intending to impugn anyone's motives, just that the communication itself was less than crystal clear. Pryde said the BOH members would have to do reading on their own outside of meetings.

James asked about the Infectious Disease personnel services listed on Page 9. Wallace said it was the total CUPHD pays to currently run all of the programs. The costs are applied to the County based on how the employee codes their time during the year. Pryde said the time coding has to be done to bill for certain grants and Medicaid.

Scholze stated the BOH will have to make cuts to its budget and asked if Pryde had any recommendations as the Public Health Administrator on where to make cuts as the costs are increasing and the demand for services are increasing. Pryde said a part of her job as Administrator is to make those recommendations and that is presented in the CUPHD budget proposal. Scholze noted the CUPHD proposal is more money than the BOH has. Pryde said her professional opinion to the BOH was to give priority to the core services and dental. She recommended the BOH not do the other services or programs. She would not cut the funding to dental because CUPHD does not do it. She was trying to be as clear and honest as possible with the budget. Scholze said the BOH appreciated the work CUPHD has done. Pryde said she has been advising the BOH since November to steer towards public health, not senior services or mental health. Pryde suggested the BOH look at trying to preserve the dental program in some way even though it is not a core service.

Rappaport said the BOH needed to have a conversation about what its policy should be. The bulk of the BOH's expenditures are in CUPHD and the Board may need to cut back on some of the things it's paying for through CUPHD. The core services are expensive relative to the BOH's revenue. Pryde said she was recommending cutting all non-essential services and funding core services and the dental program. She said the $606,567 CUPHD budget proposal was not a budget that can be trimmed. Rappaport wanted a clearer legal opinion on what constitutes the core services and what the BOH's responsibilities are.

Kassem appreciated Pryde's recommendation, but in reality the BOH may be forced to eliminate the dental program because the core services are more expensive than the BOH can afford. He would hate to see the dental program eliminated. James acknowledged that the BOH was not previously paying for some services, which attributed to the increased cost. He noted doctors and dentists pass their increased costs of doing business onto their clients. He wanted the BOH to work with CUPHD because they have been gracious and not put up a battlefront. Rappaport and Scholze emphasized that no battle were intended, the BOH members were trying

to comprehend the CUPHD budget proposal. Pryde stated CUPHD is not charging more for core services than the BOH's has in its total budget.

Segal asked about flu clinics. Pryde confirmed CUPHD would hold its drive-through flu shot clinics, but it would not hold any in other locations. Segal asked for Pryde's recommendation as Administrator on what the BOH should do for flu clinics if the mobile program is eliminated, including the costs involved. Pryde agreed to provide a recommendation when she has more information on how many shots will be required and what the hospitals will do. Other entities hold flu shot clinics and charge the same fee as CUPHD, so they will have to do a good assessment this year to avoid wasting resources. Rappaport asked for clarification on what services CUPHD could provide for the amount of dollars the BOH can spend and what is best way to spend those dollars. Segal asked if the state uses the goals and objectives public health comes up with every ten years goals to judge county health departments. Pryde answered they did and confirmed CUPHD does a local assessment of need every five years. Segal wanted to know how the BOH is progressing in meeting needs of County residents. Rappaport believed the problem is the BOH does not have its own functioning public health services. Instead it contract for these services with an outside agency that has its own board. The BOH should be setting policy, but it has nothing to control with its policy. He felt Pryde was doing her job well, but the current structure with CUPHD and BOH places the Administrator in a conflict of interest.

Smile Healthy – Presentation

Nancy Greenwalt presented the Smile Healthy FY2010 budget proposal. The total FY2010 Smile Healthy budget proposal was $133,128, an increase over the FY2009 budget of $130,360. She began with a narrative, describing how the program enables County kids to be seen in a private practice office for dental work. The program sees about 500 kids a year. Smile Healthy is a comprehensive program where the kids are seen by a dentist twice a year. A typical appointment can be three treatments. BOH funding is also used for the mobile dental clinics where Smile Healthy goes to County schools. Medicaid should be covering most of these costs, but Medicaid is slow on providing any reimbursement. Greenwalt explained that if she had to rely solely on Medicaid, then the mobile clinics would be shut down. BOH funding also goes for education programs and Greenwalt noted four more events were added for May. The $47,000 of the BOH's budget is spent on staffing, most of which helps pay for a scheduler because getting low income kids and families to dentists is a staff intensive effort. Smile Healthy uses a positive confirmation system to fill appointments and they are at 90% effectiveness. BOH's funding covers the Program Coordinator, most of whose time is spent on mobile events and the part of Greenwalt's work as Executive Director. Smile Healthy's operational costs include mileage, phones, and rent. The $75,000 is budgeted for patient care and client assistance to pay dentists will charge Smile Healthy half their usual rate. Scholze asked if the oral surgeons were paid out of patient care and client assistance. Greenwalt confirmed it included about three oral surgeries each month. The oral surgeries are very expensive, averaging about $1,000 per surgery. About a third of those patients are Head Start kids who live in Champaign-Urbana and those surgeries are paid for by Head Start. Greenwalt prepared the FY2010 budget request with a 5% increase for personnel and operations with patient care and client assistance funding remaining flat. The personnel costs did not increase more because no retirement benefits are given to staff.

Rappaport asked if Smile Healthy was providing services for approximately 500 individual County children in a year. Greenwalt said they were seeing 500 kids through the Child Dental Access Program and another 500 through mobile events. The mobile events include a dental exam, cleaning, fluoride, and sealants as needed.

Segal asked how the program identifies its clients and how those clients access the service. Greenwalt said people must initially call Smile Healthy's office and over half of clients are ongoing, established relationships. She is trying to expand restorative care. Gowda asked if the program treated children who fall below the poverty line. Greenwalt said they were 200% of the poverty level. Some of the kids are on Medicaid because most dentists do not accept Medicaid. Greenwalt bills Medicaid for mobile services and any office visits she can. If a dentist does not accept Medicaid, then she cannot bill Medicaid for the visit. None of the oral surgeons accept Medicaid.

Rappaport calculated the BOH is spending about $130 per child to receive various dental services through Smile Healthy. Greenwalt said the figure was accurate only if the cost of education services was discounted. Rappaport thought it sounded like a good buy for the service provided and per child cost. Kassem felt the program is likely servicing more than 1,000 children each year. Rappaport inquired about the consequences of various levels of funding cuts. Greenwalt said a cut of $10,000-$20,000 would be taken out of patient care and would dramatically cut her ability to provide oral surgery. The effect of a cut of more than $20,000 would be complicated and depend on the BOH's priorities. If the BOH does not fund this program, 500 private office visits would stop and the mobile clinics would be dependent on whether Medicaid would pay. Greenwalt would not set up mobile clinics in small towns because they would not see enough Medicaid kids to cover the expense.

Segal asked if the 500 office clients were required to reapply every year to show financial need. Greenwalt answered no and explained there was no screening after the initial screening. Kassem said his practice requires that low income clients present the medical card they receive each year to show their need to participate in the program. Peterson suggested Smile Healthy consider structure changes. He never liked the inefficiency of sending clients to private dentists, although the service quality is good in the private setting. It would be more efficient to have public health dentists work out of a public health office like Frances Nelson and he was disappointed it cannot get started at CUPHD. Greenwalt believed that CUPHD substantially underwrites its dental clinic with property tax revenue even though they only see Medicaid recipients. She did not think a dental clinic could be self-sufficient on Medicaid reimbursement and could not say whether it would be a more efficient way to see more clients. This is something she is trying to explore and is talking to dentists about renting office space on one of their closed days. Kassem said a big problem is a lot of dentists do not accept public aid because the Medicaid reimbursement is so low and late. Legislative ideas are being developed with objectives to implement clinics throughout Illinois concentrating on rural area. He saw Smile Healthy as a kind of a model for public aid programs. Rappaport thought there was a lot to be said for the blending public and private practices and the amount of attention Smile Healthy focuses on getting the patients scheduled. Peterson remarked the effort has to be done because only about 20% of Medicaid recipients keep scheduled medical appointments on their own and

the rest are no shows. Greenwalt added that many dentists in the program drop participants if the individuals fail to show for an appointment.

Rappaport said the BOH will have to determine what programs at what levels it can afford to support in FY2010. He was impressed with the work Smile Healthy is able to accomplish with the amount of funding it receives. Kassem liked the directness of Greenwalt's presentation. Peterson asked to see Smile Healthy's entire agency budget. He especially wanted to see how the Head Start portion fit into the entire program. Greenwalt said Head Start is about $80,000 of Smile Healthy's budget. Greenwalt said she could provide the 2008 total agency budget and Peterson agreed that would be fine.

RPC Senior Services – Written Request

Scholze noted the Regional Planning Commission's budget proposal for the Senior Wellness Program showed the BOH is paying for a RPC staff person. Rappaport pointed out the BOH is paying $11,318 for administration/indirect costs out of a $50,000 budget. He thought it was very high for indirect costs. Busey said the RPC indirect administrative rate is between 45%-48% and is charged on all personnel dollars. The rate is determined and defined because of the number of federal grant programs that RPC administers. Smaller local programs need to closely analyze whether this is the best use of their dollars because RPC charges this rate to every program it administers. In Rappaport's experience at the University of Illinois, foundations could negotiate a lower indirect cost than what was charged to federal grants. Busey said application of the single indirect rate to all programs could be a policy decision made by the RPC Commission. She would follow-up with the RPC Financial Officer. Rappaport posed the questions of whether the BOH could afford this program and whether it is getting value from the program. Scholze wanted to compare the budget to the data on the number of people served provided by RPC. Rappaport thought the last report from RPC provided the number of people that RPC provided information to and he was worried about the ability to provide senior services in rural areas.

Rappaport asked Busey what the BOH could actually afford in terms of total dollars and maintain a 25% fund balance. The Board discussed setting a fund balance goal of 25% at its May 12th study session. Busey said the next question was how fast the BOH wanted to spend down its fund balance. She recommended the order of events at the June meeting be the legal opinion on the core services, designation of a fund balance goal, determining how much of the fund balance to appropriate in each fiscal year, and then selecting which programs to fund.

Peterson wanted to know whether the Senior Wellness Program was just not up to speed yet or if this was all there was with the program. Busey noted RPC had an entire Senior Services Program in place prior to receiving funding from the BOH. The BOH might want to learn about what the RPC Senior Service Program does and determine whether it is already meeting the need the BOH wanted. Rappaport and other Board members have come to the conclusion that the Senior Wellness Program was not matching what the BOH anticipated when it starting funding the programs two years ago. It was noted that it is not a core service.

Rappaport wished the BOH had an independent Administrator who would focus on getting the County core services at the best price. The Board discussed the many different services that are public health services even though they are not core services. Peterson remarked that CUPHD made a decision to move into an expensive remodeling program and the BOH is paying part of the overhead costs. James questioned that statement because he did not see any utilities or building costs included in CUPHD's budget proposal. McGrath said those costs were included under the Occupancy line in the CUPHD budget proposal. Rappaport said CUPHD's cost of doing business affects what the County is charged and the BOH has no input into CUPHD policy decisions. Busey suggested that the BOH could ask for the difference in cost for the BOH between CUPHD adopting the full IMRF rate versus the phase-in IMRF rate and let the CUPHD Board know. The difference might not be a huge amount of money, but it would be useful for the BOH to know how that expense is affecting them. Peterson said it would be nice to see the entire CUPHD budget to understand what portion the County makes of that budget. Kassem said he has not been entirely comfortable with the BOH having to say over the selection or retention of the Administrator. The CUPHD Board makes the decisions about hiring or replacing an Administrator. He did not think anyone could be the Administrator to both boards. In the current situation, the Administrator's main job is to take care of CUPHD. Busey suggested an individual could administer to both boards if they had an intergovernmental agreement instead of a contract. Similarly, the Champaign Mental Health Board and Developmental Disabilities Board employ a single Administrator together. The Board discussed the structure of the Board and the contract. Rappaport suggested holding a study session with the CUPHD Board to raise these types of questions about how to better serve good government in Champaign County. He noted one of the three-person CUPHD Board represents the County as the County Board Chair. Peterson supported raising the IMRF issue with the CUPHD Board. Peterson asked Bork to email the BOH the schedule of CUPHD meetings and study sessions. The BOH asked Busey to request the dollar difference in the IMRF rates and the total CUPHD budget from Wallace. Busey suggested it might be helpful for the BOH to see the personnel costs billed to the County in terms of dollars as well as the personnel percentages CUPHD provides. The dollar amounts corresponding to the percentage of personnel charge to the County would enable the BOH to see the cost and it is public information. The BOH concurred and asked Busey to request this information from CUPHD.

Mental Health Board Crisis Nursery Program – Written Request

Rappaport drew attention to a letter from Peter Tracy in the written request and described the most recent quarterly planning meeting between the two boards held last Thursday. The Mental Health Board (MHB) wants to continue the Crisis Nursery Beyond Blue Program for another year. Additionally, the MHB plans to fund the program's extension into Champaign-Urbana. The BOH's funding would not be used for the extension into Champaign-Urbana. The MHB will not go ahead with the Beyond Blue Program in the County if the BOH does not support it in FY2010. Rappaport wanted to give the MHB some indication on whether BOH will continue its collaborative funding in the next fiscal year and asked for opinions from the Board. He did not what to stop the collaborative work with the MHB after just one year. Tracy is interested in having closer relations between the MHB and BOH, and Rappaport thought the BOH would benefit tremendously from that relationship. The MHB has a great deal of money and they are very careful in how they use it. MHB is interested in talking with the BOH about

having a presence in the County and asking agencies that submit applications to move towards activities compatible with the public health policies. It was understood that if the FY2010 funding was approved, the MHB would not receive the $25,000 until December. In Rappaport's opinion the BOH probably has sufficient fund balance to fund this program in FY2010 and he would like to have an indication about BOH's intention of whether or not to fund this program. This would enable the MHB to move ahead with its programming for the next year, but he would not do so if the BOH was not in favor of it. Peterson inquired if the MHB could wait until June for an answer. McGrath said the contract ends June 30th and Rappaport felt the sooner the decision was made the better. He did inform Tracy that the BOH would probably not vote on budget requests until June. Gowda asked if they were talking about the County program or the expansion program. Rappaport verified the BOH would only be involved in the County program. The Champaign-Urbana expansion was a separate MHB issue. Rappaport called for a straw poll on the BOH's opinion to continue the MHB collaborative program for another year. Seven Board members were in favor of the program with one Board member against. Peterson asked James why he objected. James explained he was not indicating that he was not in favor of the program; he did not want to make any decision or comment until the BOH sees the entire budget because it is misleading to another agency. He did not want to single out one program. Segal commented that she raised her hand because she would like to support the program if the BOH can afford it. Peterson stated the BOH can afford the program this year. Busey clarified that the BOH could pay for the program out of its fund balance and would not be paying for the program out of FY2010 operating expense. This would be a decision to spend down the fund balance. Segal thought the Crisis Nursery had done an excellent program with Beyond Blue. Rappaport would communicate with Tracy that the BOH will likely vote in June to make a commitment for FY2010.

Issues Regarding CUPHD

All CUPHD issues were discussed during the budget presentation.

Issues Regarding Smile Healthy (Kassem)

All Smile Healthy issues were discussed during the budget presentation.

Other Business

Update on Environmental Health Fees

No update was provided by legal counsel.

Date of June Meeting

The next Board of Health meeting has been scheduled for June 23, 2009 at 6:00 p.m.

Rappaport asked for McGrath to provide the legal opinion before the day of the meeting and asked to talk to her before she writes the legal opinion.

Public Participation on Non-Agenda Items Only

There was no public participation on any non-agenda items.

Adjournment

The meeting was adjourned at 8:27 p.m.

Respectfully submitted,

Kat Bork
Board of Health Secretary

Secy's note: The minutes reflect the order of the agenda and may not necessarily reflect the order of business conducted at the meeting.

CHAMPAIGN COUNTY BOARD OF HEALTH

Special Meeting
Tuesday, May 12, 2009, 6:00 p.m.

Call to Order & Roll Call

The Board of Health held a special meeting on May 12, 2009 in the Jennifer K. Putman Meeting Room at the Brookens Administrative Center, 1776 East Washington, Urbana. The meeting was called to order at 6:01 p.m. by Julian Rappaport. Board members Brenda Anderson, Stan James, Cherryl Ramirez, Julian Rappaport, and Bobbi Scholze were present at the time of roll call. Peterson entered the meeting after roll call. Absent Board members were Prashanth Gowda, Nezar Kassem, and Betty Segal. The staff member present was Susan McGrath (Senior Assistant State's Attorney). Also present was Deb Busey (County Administrator of Finance & HR Management).

Approval of Agenda/Addendum

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

Public Participation

There was no public participation.

Senior Wellness Program Contract Renewal for FY2009

Rappaport noted the Board of Health has not officially approved the contract renewal for the current fiscal year for the RPC program. The renewal was prepared by McGrath.

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

MOTION by James to approve the Senior Wellness Program Contract Renewal for FY2009; seconded by Ramirez.

McGrath stated the renewal set out what the normal payment dates would be even though two of the dates have passed. She said the dates had to be in the contract renewal for the Auditor's Office to actually pay the bill submitted by the Regional Planning Commission. The money for the program is budgeted in the FY2009 Board of Health Budget.

Motion carried.

Rappaport noted that the contract renewal needed to be signed by the officers after the election later in the meeting.

CUPHD Invoice for February 2009

Peterson stated the invoice was consistent with the previous invoices.

MOTION by Peterson to approve payment of the CUPHD invoice for February 2009; seconded by Scholze. **Motion carried.**

Election of Officers

McGrath stated the Board has to elect officers every year according to its bylaws. Rappaport asked if the officers were elected one at a time. McGrath stated the officers could be elected as a slate.

MOTION by James to elect the same slate of officers; seconded by Scholze.

Rappaport commented the current slate of officers consisted of himself as President, Peterson as Treasurer, and Gowda as Secretary. He noted that Gowda is frequently unable to attend meetings, which can be a problem when items like the contract renewal approved tonight needs to be signed. Peterson suggested another candidate be considered for Secretary. Rappaport nominated Ramirez as Secretary. Peterson seconded the nomination.

James and Scholze agreed to consider the substitution of Ramirez as the Secretary as a friendly amendment to the original motion.

Ramirez asked if she would be required to take minutes of the meetings. The Board explained those duties were handled by Kat Bork, the Board's Administrative Secretary. Ramirez would be called upon to sign contracts as an officer and chair meetings in the absence of the President. Ramirez did not object to being elected Secretary.

Motion carried as amended.

Other Business

There was no other business.

Adjournment

The meeting was adjourned at 6:11 p.m.

Respectfully submitted,

Kat Bork
Board of Health Secretary

Secy's note: The minutes reflect the order of the agenda and may not necessarily reflect the order of business conducted at the meeting.

CHAMPAIGN COUNTY BOARD OF HEALTH

Study Session
Tuesday, May 12, 2009, 6:15 p.m.

Call to Order & Roll Call

The Board of Health held a study session on May 12, 2009 in the Jennifer K. Putman Meeting Room at the Brookens Administrative Center, 1776 East Washington, Urbana. The meeting was called to order at 6:15 p.m. by Julian Rappaport, immediately following a special meeting. Board members Brenda Anderson, Stan James, John Peterson, Cherryl Ramirez, Julian Rappaport, and Bobbi Scholze were present at the time of roll call. Absent Board members were Prashanth Gowda, Nezar Kassem, and Betty Segal. The staff member present was Susan McGrath (Senior Assistant State's Attorney). Also present were Deb Busey (County Administrator of Finance & HR Management), Julie Pryde (CUPHD Administrator), and Andrea Wallace (CUPHD Finance Director).

Approval of Agenda/Addendum

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

Public Participation

There was no public participation.

Board of Health Budget Discussion

Rappaport noted updated budget documents were distributed by Busey and CUPHD. Peterson recommended the Board members mark the revised documents with the date to prevent confusion at a later date. Rappaport asked about the changes CUPHD was requesting that differed from the current budget. Wallace stated all the changes were included in CUPHD proposed FY2010 contract budget. Rappaport suggested the Board have an informal conversation about the budget. James asked for Busey to explain the condition of the Board's finances at present and project where they would be at the end of FY2009 before moving onto discussion about the FY2010 budget. Busey explained the FY2009 budget is based on what was budgeted by the County Board of Health (BOH) for its expenditures and revenues for this fiscal year. Busey does not always have the most current information on grants and fees revenues from CUPHD, so she indicated what was originally budgeted. CUPHD should have a better idea as to whether the collections would match what is budgeted for FY2009. On the document distributed by Busey, the top large box is the CUPHD contract with the total grants, including the Local Health Protection Grant, the Tobacco Free Community Grant, the Bio-Terrorism Grant, and the West Nile Virus Grant. According to the original budget, the total revenue from those grants was $234,050 and the total expenditures associated with those grants were $253,319. This left a revenue shortfall of $19,269. The Local Health Protection Grant covered the Infection Disease Prevention & Management (the mobile unit program), Maternal & Child Health Management, and IBCCP & Clinical Services. James asked if the shortfall comes out of the BOH's fund balance even though the grants were supposed to cover the expenditures. Busey said yes and would explain the shortfall as she went through the budget. She drew the correlations based on

the way CUPHD presents its information and Wallace concurred with her correlations. Busey pointed out the next box on her document concerned Environmental Health, where fees revenue is received. The fees revenue for food protection permits, private sewage permits, well water permits, and EPA Public Water System Supervision was budgeted at $140,813 this year. Environmental Health expenditures, according to CUPHD's original budget document, are $319,627. The Environmental Health revenue shortfall is $178,814. There are also administration costs for CUPHD to administer the contract in the amount of $87,643. There is no grant or fees revenue to offset the administration costs. Busey stated the BOH receives total revenue of $374,863 and has total expenditures of $660,589 for the FY2009 CUPHD contract. The shortfall is $285,726.

In the next box, Busey listed the BOH's other revenues. The property tax is the revenue that offsets the expenditures that are in excess of grants and fees for the CUPHD contract. The BOH property tax revenue is budgeted at $373,184 in FY2009. With the addition of investment interest and the County Board grant, the revenue totals $430,184. The other expenditures are budgeted to include the Smile Healthy program of $130,360, the RPC Senior Wellness Program of $50,000, clerical support of $10,000, and conferences expenses of $1,000. The BOH's total FY2009 budget is $805, 047 in revenue and $851,949 in expenditures. This leaves the BOH with a deficit of $46,902 this year.

Peterson said the $25,000 of the Mental Health Board collaboration was missing. Busey said that was appropriated from last year's budget and the Board had not approved it this year. Rappaport understood that if the Mental Health Board collaboration funding was approved for another year, then it would be taken out of the next fiscal year. Busey thought there was a misunderstanding because the Mental Health Board collaboration funding was added to last year's budget and not added to this year's budget. However, the BOH only paid half of the amount last year, so a budget amendment was done to pay the remaining balance of $11,000. She did not reflect the Mental Health Board funding in this budget document because she did not know if it was an ongoing expense. Rappaport said the BOH would have to discuss the continuation of that program at night's meeting. Busey explained that the second page of her document is what the adjusted FY2009 budget would be based on the contract expenses proposed by CUPHD at the last meeting, which was a total contract of $830,642. CUPHD requested increase in FY2009 for administration and Environmental Health that increased the total cost of the CUPHD contract by $170,000 in FY2009. Busey prepared this page at Peterson's request. The BOH already has a contract with CUPHD based on the first page. The second page reflects the request made by CUPHD for increases to the FY2009 contract budget. Busey also prepared a look at the FY2010 and noted that CUPHD distributed a different proposal for their FY2010 budget tonight. Busey advised that unless there was a significant change in fees or grants, the FY2010 total revenue is projected at $751,058. To adopt a balanced budget, the BOH would have to keep its expenses consistent with that revenue amount. The adjusted proposal from CUPHD in FY2009 would severely overspend revenue in FY2009 and FY2010. The BOH fund balance would quickly be depleted and BOH would be at a point of deficit spending by FY2011 unless some adjustments are made.

James asked if Busey was confident about the projected FY2010 property tax revenue. Busey said she was as confident as she could be at this point. The projection is based on an

overall county-wide growth in EAV of 3%, which is half of what it has been the last two-three years. This is a realistic number for EAV growth at this time according to the Supervisor of Assessments. Busey applied the tax cap calculation with the allowed 1.8% CPI increase. James was aware that foreclosures are starting to hit small communities. Busey reminded the Board that there may be some issues with collecting the property tax. James noted the County Board would not be continuing its grant to the BOH. Busey noted the BOH was informed last year that FY2009 would be the last year of the County Board Grant. James and Busey expressed that the County Board was facing some serious deficits with its budget. Based on the FY2009 budget that is place, the BOH would end this year with a fund balance of about $392,000. Any expenditure in excess of revenue is taken out of the fund balance next year. She wanted the BOH to be aware of what's happening to its fund balance as they plan for the subsequent year's expenditures.

The Board discussed its budget. James said the Mental Health Board collaboration would add to the projected deficit in FY2010 if it was continued. Peterson added the Mental Health Board collaboration amounted to $25,000 in a fiscal year. Busey agreed that was not currently included in the FY2010 budget projections and would draw the fund balance down even more.

Pryde said they are discussing the idea of people needing three flu shots this year and that would be a huge mess. James asked what solution the BOH could have for expenses related to a grant which are in excess of the grant amount instead of spending its fund balance. He asked if the BOH had to do the grants if the money is not sufficient to cover the expenses. Rappaport asked if the BOH had to spend more than the grants provide in order to continue being a public health department. James asked which grants were being overspent. Busey stated the Local Health Protection Grant is the one being overspent. The other grants are basically pass-through funds. Pryde agreed that Busey was accurate. Peterson said the Illinois Breast & Cervical Cancer program was not balanced. Busey pointed out that was listed as being paid for by the Local Health Protection Grant. James wanted to see what the BOH was receiving and what alternatives it had to taking money from its fund balance or other revenues. He asked if it was mandated that the BOH had to pay those total operating costs. Peterson said other counties do not pay the total costs; instead they quit paying at the point when the grant money is gone. The patients, doctors, or hospitals absorb the costs. James asked if the services under the Local Health Protection Grant more important than some of the other programs the BOH is funding. Rappaport concurred that was a question the BOH would have to discuss. He encouraged asking questions like that about every program to get all questions on the table.

Scholze inquired if the BOH traditionally set a budget that runs a deficit. Peterson said the BOH has set a deficit budget, but only with the proviso that he deficit would be taken out of the carryover so it was not really deficit spending. Busey drew the Board's attention to Page 4 of her document where the revenue and expenditure totals for each year were shown on a bar chart. The totals shown are the actual revenue and expenditures, not what was budgeted. Scholze asked how the fund balance accumulated. Busey explained that the BOH built a fund balance by not spending all the revenue it received each year from 1998 (when the tax went into effect) to 2003. Ramirez asked if the BOH had a policy to maintain the fund balance at a certain percentage of its budget. Busey recommended the BOH establish what it would like the fund balance policy to be because that decision should come from the Board. A fund balance policy

has not been established. From a cash flow standpoint, Busey recommended establishing at least a 12.5% fund balance because a substantial portion of the BOH's revenue comes from property taxes. Property tax revenue is not received until the third quarter of a year, so the BOH needs cash flow to carry the budget though until the tax revenue is received. A 12.5% fund balance goal is standard for funds where a significant portion of revenue is derived from property taxes. The BOH could set a higher fund balance goal.

Peterson said it was acceptable, if not expected, that the BOH would spend down some of its fund balance. The BOH has approved previous budgets with the expectation that a portion of the fund balance would be spent. What actually happened was the property taxes revenue came in better than expected and, for some reason or other, one of the budgeted programs did not come together, reducing the anticipated expenditure. Peterson remarked that it became clear a couple of years ago that this pattern would not happen any longer and the BOH would start spending its fund balance. Rappaport asked what a 12.5% fund balance would amount to and Busey stated it would be 12.5% of the FY2010 operating budget. The exact amount would depend on the amount of the FY2010 budget. Peterson calculated a minimum fund balance of $105,000 would be skating on thin ice. James added that the BOH is not obligated to make a payroll. Busey stated the BOH has to be able to meet its monthly expenses. Peterson said he would be more comfortable will a $250,000 fund balance goal. Scholze suggested a goal of at least 20%. This is the amount required by Parkland, which relies on property taxes but also has a lot of other revenue sources. Ramirez remarked that the not-for-profit she works for maintains a six-month or 50% fund balance because they are reliant on membership dues. Ramirez and Scholze agreed with Peterson that a fund balance goal of only $105,000 was worrisome. Busey noted the BOH relies on grants and fees collection, which can be dicey. The County Board has funds within its fund structure that have fund balance goals of 100% because they want the flexibility to be able to phase down spending when faced with unexpected cuts. She thought a 20-25% fund balance goal was completely realistic for a fund like the BOH. The Board continued to discuss the fund balance goal and agreed it wanted to set a fund balance goal. Peterson noted the BOH depends on federal and state grants. The state grants are very much in question right now with the turmoil of the state budget. Peterson warned that the BOH would face tough decisions at some point if it approved deficit budgets spending down the fund balance. The BOH would reach a point that it no longer had reserves to cover operating expenses in excess of revenue.

The Board continued its discussion over the FY2010 budget.

Adjournment

The meeting was adjourned at 8:15 p.m.

Respectfully submitted,

Kat Bork
Board of Health Secretary

Secy's note: The minutes reflect the order of the agenda and may not necessarily reflect the order of business conducted at the meeting.

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Office of
State's Attorney
Champaign County, Illinois

TO: Champaign County Board of Health
Deb Busey, Champaign County Administrator

FROM: Susan W. McGrath
Senior Assistant State's Attorney

RE: Standards for required programmatic activities of local health departments

DATE: June 17, 2009

The Board of Health has directed me to research what a local health department is required to maintain programmatically in order to maintain its certified status with the State of Illinois, in order to be better prepared to analyze your budget for the coming fiscal year. Throughout this memo, I have cited various parts of the Illinois Administrative Code (which is identified as IL ADC) to assist the Board in ascertaining the answer to this inquiry.

The Champaign County Public Health Department is required to provide four core programs in order to be certified by the Illinois Department of Public Health—Infectious Disease; Food Protection; Potable Water Supply (well water); and Private Sewage Disposal. These programs are supported by the Local Health Protection Grant program through the State of Illinois Department of Public Health and "are intended to supplemental other federal, state and local funds available to support public health programs, including the four programs that must be assured for participation." 77 IL ADC 615.210. The four core programs may be provided by direct service, or by another unit of local government. 77 IL ADC 615.200. In addition, the county health department must also have a 24 hour notification system, and a current, all hazard emergency response/disaster plan for their jurisdiction. 77 IL ADC 615.340.

The State Department of Public Health "shall provide review and consultation to local health departments in order to evaluate the effectiveness of local health activities and programs and to determine the extent of compliance with the grant agreement." 77 IL ADC 615.220. This review and consultation is supposed to be provided at least once every three years. The health department has the right to apply for a temporary waiver of any of these required services for a period up to six months, and the waiver can be extended for two more consecutive service periods. The local department must show that

the waiver is necessary "due to conditions or circumstances beyond the reasonable control of the local health department" and that "fulfilling the requirement at this time would jeopardize compliance with a higher priority activity needed to protect the health and safety of residents within the local health department's jurisdiction." I am bringing this waiver provision to the attention of this Board because there could be foreseeable circumstances, such as the provision of and payment for treatment of contagious tuberculosis patients, which would mandate use of the Board's funds for this priority rather than some portions of the four core programs.

The Administrative Code does in fact contain some established standards by which the Public Health Department's four core programs are to be evaluated. Those standards are found at 77 IL ADC 615.300 (Infection Disease); 77 IL ADC 615.310 (Food Protection); 77 IL ADC 615.320 (Potable Water Supply); and 77 IL ADC 615.330 (Private Sewage Disposal). I have attached those standards to this memo for your review. I would note preliminarily that the number of staff to be provided for each of these activities is not proscribed by statute or code with the exception of one person in each category who must have the particular credentials required by the code for that category. In addition, the Infectious Disease program includes a provision that the services to provided as part of that program are negotiated with the State in order to determine the level of services which is appropriate to offer, as opposed to the more specific requirements for food safety, well water, and private sewage disposal programs.

Here are the significant portions of those standards for your review:

1. Infectious Disease

a. Infectious Diseases are defined in 77 IL ADC 690.900, which is attached to this memo. There is also a more specific listing of the kinds of diseases considered to be infectious diseases in 77 IL ADC 690.1000, which is also attached to this memo.

b. Trends are to be tracked in HIV, Tuberculosis, communicable diseases, and sexually transmitted diseases on an annual basis, and used "in combination with other program activity measures" in order to assess program performance and undertake program planning."

c. "For reported cases involving Tuberculosis and sexually transmitted diseases, a negotiated percentage of reported cases receiving treatment for infectious diseases shall complete the course of therapy included within a list of Department-approved guidelines for prevention and treatment of Tuberculosis and sexually transmitted diseases." This is important because it means the Department does not have to provide treatment for every single one of these cases, but can work with the State Department of Public Health to determine what the county is responsible for in this regard.

d. The county is not required to provide public health infectious disease clinics. Rather, this standard says that they "should" be conducted.

e. "Screening for Tuberculosis and HIV shall be conducted as determined by the results of a needs assessment of the community. If the needs assessment does not

address this issue, goals for such screening shall be negotiated" with the Illinois Department of Public Health.

f. The county is required to develop and maintain ongoing immunization clinics. These clinics **should** assist schools to comply with the school code and meet community needs as developed by the federal government. If there are outbreaks, "special immunization clinics **shall** be provided of such number and frequency as needed to control the spread of disease." In other words, there is a mandate for these clinics when there are outbreaks of communicable disease, and for the ongoing immunization clinics, the standard is more relaxed.

g. "The local health department **shall** assist and support the completion of annual surveys of selected populations, i.e., school enterers, special age groups or communities." These surveys then **should** be used to plan and conduct activities to increase immunization levels for specific diseases.

h. "Qualified personnel shall be available to conduct the activities pursuant to this Section. One or more staff members involved in infectious disease investigations has to have special CDC training.

i. For letters b-g above, the local health department is to negotiate with the State Department of Public Health every three years as to the percentages for activities to be conducted in those programs. These reviews are what really determine the goals that the county health department should be meeting in the area of infection disease.

II. Food Protection

The county health department is required to undertake activities identified in this section of the code which are meant to identify, reduce and whenever possible eliminate factors which may cause foodborne illnesses in order to reduce the incident of such illnesses. This includes:

a. Having a county health ordinance which incorporates at least the same requirements as the Food Service Sanitation Code and the Retail Food Store Sanitation Code

b. Maintaining a listing of all food service establishments and retail food stores which are broken down into three categories.

c. Conduct plan review, pre-operational inspections, follow-up inspections, consultation and enforcement actions as necessary to ensure correction of deficiencies and violations of applicable ordinances.

d. Create a surveillance and control system to monitor, identify and record instances of food borne disease, detect sources of contamination, establish factors that contribute to outbreaks, and to recommend preventive control measures and take appropriate action to prevent further spread of disease.

e. Provide information to the general public concerning prevention of foodborne illness, including primary and secondary schools to teach children about food safety.

f. Provide a program designed especially for food establishment managers and personnel.

g. **Have at least one supervisor or training officer standardized and certified bienally in food safety practices and food sanitation by the FDA.**

III. Potable Water Supply

"The focus of this potable water supply program **shall** be non-community, semi-private and private water supplies; however, during a water emergency requiring public notice, the local health department **should** assure provision of potable water for all of its constituents." This includes:

1. A program to be conducted pursuant to a local ordinance that incorporates state standards for water wells and water well pumps.
2. Maintains current listings of the names and addresses of all non-community public water supplies.
3. Operate a routine water sampling program for all non-community public water supplies as required by statute.
4. Sample all non-community public water supplies at least every two years.
5. Requests for sampling related to semi-private or private water supplies "**shall be evaluated regarding its public health significance**. Request determined to have a valid public health purpose shall be inspected within 7 days."
6. Every licensed contractor installing wells must have at least one well they have constructed within that calendar year inspected by the Department.
7. Samples have to be collected from all new water wells "unless the local health department ensures that the homeowner or his agent will collect and submit a sample to a certified laboratory."
8. Abandoned wells have to be sealed by the property owner.
9. "Qualified personnel shall be available to conduct these activities," with new program staff to complete a Department provided orientation and training program, and then go to annual training thereafter.

IV. Private Sewage Disposal

"The local department shall establish a program to prevent the transmission of disease organisms, environmental contamination, and nuisances resulting from improper handling, storage, transportation and disposal of sewage from private sewage disposal systems." The local health department is required to provide the following activities:

1. The program must be conducted pursuant to a local ordinance that is at least as stringent as the Private Sewage Disposal Code.
2. In coordination with "appropriate state and local agencies," long and short range plans **should** be developed for the protection of the environment and protection of the health of the people within its jurisdiction."
3. All subdivision plats with private sewage disposal systems have to

be reviewed and approved, along with all new, altered, repaired or replaced private sewage disposal systems.

4. There must be an annual evaluation of all septage hauling equipment, storage facilities and land disposal sites.

5. Complaints have to be investigated within 10 working days. If violations are identified, voluntary compliance shall be sought, with enforcement to occur if there is no voluntary compliance.

6. "Educational materials regarding the proper handling and disposal of sewage shall be made available to the public upon request.

7. New program staff have to go through State orientation and training, and there is also annual training required.

V. General Requirements (These items are also attached to this memo)

All local health departments have to maintain a 24 hour notification system that the state, hospitals, or members of the general public can contact to promptly reach a staff person to report a suspected or actual public health incident or event. This system has to be tested at least quarterly to make sure it is operationally reliable, and the system in place has to be documented. 77 IL ADC 615.340.

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The Board had also inquired as to what role, if any, the Public Health Department has in relation to mental health services. 59 IL ADC 103.70 states that county health departments established by either referendum or resolution have the option to provide mental health and developmental disabilities services, and can provide the services directly, or by contract with existing providers of services either within or outside the grographic service area. In the event the Public Health Department opts to provide such services, it must appoint a mental health and developmental disabilities services advisory committee. While this is not a mandated service the county health department must offer, the statutory scheme envisioned here allows for integration of such services.

I hope that this information is of assistance to you in the study of your budget for the coming fiscal year. Please do not hesitate to contact me if you have any questions in this regard.

WEST'S ILLINOIS ADMINISTRATIVE CODE
TITLE 77: PUBLIC HEALTH
CHAPTER I(1): DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER H: LOCAL HEALTH DEPARTMENTS
PART 615: LOCAL HEALTH PROTECTION GRANT RULES
SUBPART B. ADMINISTRATION OF LOCAL HEALTH PROTECTION GRANTS

This document is current through June 12, 2009

615.210 Purpose and Distribution of Grant Funds

a) The purpose of the Local Health Protection Grant program is to support a statewide system of local health departments to assure the protection of the public through the provision of various health protection programs. Local Health Protection Grants may be used by the participating local health department for any health protection program or service including, but not limited to, Infectious Diseases, Food Protection, Potable Water Supply, and Private Sewage Disposal. The Grants are intended to supplement other federal, State and local funds available to support local health protection programs, including the four programs that must be assured for participation. Provided the four programs are assured, the local health **department** may use the Grant funds for any health protection program, activity or service, or for shared management or administrative support costs.

b) The **Department** shall award Local Health Protection Grant funds using a methodology developed in cooperation with the Illinois Association of **Public Health** Administrators and the Northern Illinois **Public Health** Consortium; however, the Director shall make the final determination of the methodology used. The allocation methodology shall be based upon the following criteria: population; number of persons with incomes below 200 percent of the Federal Poverty Level; and historical grant award levels.

c) Local health departments participating in the Local Health Protection Grant program shall receive, subject to the availability of funds, annual grant awards calculated by one of the following methods:

1) An amount equivalent to the previous year's award, adjusted for inflation, shall be reserved for each local health **department** that participated in the grant program the previous year. After that amount is reserved, additional funds shall be allocated to participating local health **departments** to achieve the following cumulative allocation:

A) Fifty percent (50%) of the annual Local Health Protection Grant funds shall be allocated based upon the populations of the local health **departments'** jurisdictions; and

B) Fifty percent (50%) of the annual Grant funds shall be allocated based upon the numbers of persons with income below 200% of the Federal Poverty Level within local health **departments'** jurisdictions.

2) Minimum and Maximum Grant Awards. This subsection applies to all participating local health **departments**.

A) Subject to the availability of funds, the **Department** will establish a minimum grant award level annually. The minimum award will be applied if the methodology specified in subsection (c)(1) of this Sec-

tion would result in a grant award to a local health **department** that is less than the minimum award. The minimum grant shall not be less than $50,000. The minimum annual grant award to any participating multi-**county** local health **department** shall be the minimum award times the number of **counties** in the multi-**county** local health **department**.

B) If available Grant funds increase in subsequent fiscal years, the **Department** shall raise the minimum annual grant awards for participating single-**county** (or partial-**county**) local health **departments** by the same percentage as the percentage increase in Grant funds available for previously-participating local health **departments**.

C) If the methodology will result in a local health **department** receiving a grant award that will adversely affect the funding available to other local health **departments**, then the **Department** may establish a maximum grant award for that year. The maximum award shall be based on the total annual Local Health Protection Grant appropriation level, the allocation criteria, and/or the availability of other State or federal funds for performing the required programs described in Subpart C of this Part.

3) For newly certified local health **departments**, initial grant awards shall be determined by the methodology specified in subsection (c)(1)(A) and (B) or (2) of this Section.

4) Multi-**County** Local Health **Departments**. The annual grant award for each participating multi-**county** local health **department** shall equal the sum of the annual grant awards that its individual **counties** could receive as single-**county** health **departments**.

5) Maximum Annual Change. The **Department** may impose a maximum allowable annual percentage change (% increase or % decrease) in the total grant award for participating local health **departments**. Such limits shall not be imposed from one year to the next without granting the Illinois Association of **Public Health** Administrators and the Northern Illinois **Public Health** Consortium advance notice and an opportunity to comment. The Department's decision to impose the limitation shall be based on the number of participating local health **departments**, the unmet financial needs of participating local health **departments**, the adequacy of other funding available to local health **departments**, the availability of Local Health Protection Grant funds for that year, the inflation rate, and other issues affecting the fair distribution of grant funds.

6) The methodologies specified in subsections (c)(1) through (5) of this Section shall not be applied to the distribution of additional funds appropriated for the Grant program, if that additional appropriation specifies the method by which the funds are to be distributed.

d) Prior to the award of Grant funds, the **Department** and the local health **department** shall execute a grant agreement wherein the local health **department**, at a minimum, agrees to:

1) fulfill the requirements of this Part; and

2) provide program statistical information to the **Department**. The requested information will be developed in cooperation with the Illinois Association of **Public Health** Administrators and the Northern Illinois **Public Health** Consortium.

(Source: Amended at 30 Ill. Reg. 13412, effective July 27, 2006)

<General Materials (GM) - References, Annotations, or Tables>
77 ILAC § 615.210, 77 IL ADC 615.210

77 IL ADC 615.210
END OF DOCUMENT

Westlaw

77 IL ADC 610.310
77 Ill. Adm. Code 610.310
Ill. Admin. Code tit. 77, § 610.310

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PART 610. LOCAL HEALTH DEPARTMENT DEVELOPMENT GRANT RULES
SUBPART C. GRANT FUNDS

This document is current through June 12, 2009

510.310 Grant Awards

a) The **Department** shall use the population of the **county** or **counties** in which the local health **department** has jurisdiction as the basis for determining the local board of health's annual grant award.

b) The Local Health **Department** Development Grant term shall be concurrent with the State fiscal year.

c) The **Department** and the local board of health shall execute a grant agreement for the grant award within 30 days of approving the Local Health **Department** Development Grant application.

<General Materials (GM) - References, Annotations, or Tables>
77 ILAC § 610.310, 77 IL ADC 610.310

77 IL ADC 610.310
END OF DOCUMENT

Westlaw

WEST'S ILLINOIS ADMINISTRATIVE CODE
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SUBPART B. ADMINISTRATION OF LOCAL HEALTH PROTECTION GRANTS

This document is current through June 12, 2009

615.200 Eligibility

A local health department shall be eligible to receive Local Health Protection Grant funds provided that it meets the following criteria:

a) the local health department is certified pursuant to Section 600.210 of the Certified Local Health Department Code (77 Ill. Adm. Code 600);

b) the local health department makes application to the Department on forms or in a format provided or prescribed by the Department; and

c) the local health department assures that the four health protection programs of infectious diseases, food protection, potable water supply, and private sewage disposal are provided in accordance with the requirements of this Part. Assumption of direct service by another unit of local government shall fulfill this assurance for that portion of the local health department's jurisdiction.

<General Materials (GM) - References, Annotations, or Tables>

77 ILAC § 615.200, 77 IL ADC 615.200

77 IL ADC 615.200
END OF DOCUMENT

Westlaw

77 IL ADC 615.230
77 Ill. Adm. Code 615.230
Ill. Admin. Code tit. 77, § 615.230

WEST'S ILLINOIS ADMINISTRATIVE CODE
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SUBPART B. ADMINISTRATION OF LOCAL HEALTH PROTECTION GRANTS

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515.230 Waiver of Requirements

a) A certified local health department may apply to the Department for a temporary waiver of any requirement of this Part. The local health department shall submit a written application which describes and attests that:

1) the need for a waiver is due to conditions or circumstances beyond the reasonable control of the local health department; and

2) fulfilling the requirement at this time would jeopardize compliance with a higher priority activity needed to protect the health and safety of residents within the local health department's jurisdiction.

b) The Department may grant a waiver if its determines that the local health department meets the criteria specified in subsection (a) of this Section. The Department shall notify the local health department of its decision within 10 working days after receipt of the request.

1) If a waiver is granted, it shall be granted for a six-month period or until the conditions or circumstances referred to in subsection (a) of this Section are remedied, whichever is sooner.

2) The Department may extend a waiver for two additional six-month periods. All requests for extension of waiver shall be received by the Department at least 15 working days prior to the expiration of the waiver period.

A) The first extension of the waiver may be made if the Department determines, on the basis of a written explanation from the local health department, that reasonable progress has been made and the local health department can be expected to be in compliance with the waived requirement on or before the conclusion of the first extended waiver period.

B) The second extension of waiver may be made if the Department determines, on the basis of a written explanation from the local health department, that reasonable progress has been made and the local health department can be expected to be in compliance with the waived requirement on or before the conclusion of the second extended waiver period. The explanation shall include the expected dates for completion and the reasons why the local health department was unable to achieve compliance within the first extension period.

c) The Department may review the local health department for compliance upon the expiration of the waiver period or upon request of the local health department. Such review may include an on-site inspection.

<General Materials (GM) - References, Annotations, or Tables>
77 ILAC § 615.230, 77 IL ADC 615.230

77 IL ADC 615.230
END OF DOCUMENT

WEST'S ILLINOIS ADMINISTRATIVE CODE
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SUBPART C. PROGRAM STANDARDS

This document is current through June 12, 2009

615.300 Infectious Diseases

a) In order to protect the citizens within its jurisdiction from contracting and transmitting infectious diseases, the local health department shall perform a comprehensive infectious diseases control program.

b) For selected Class I(a), Class I(b) and Class II diseases listed in Section 690.100 of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690), the local health department in consultation with the Department shall jointly monitor trends on an annual basis. Disease case rates are important in the framework of measures needed to understand the outcome of disease control efforts, but should not be interpreted in isolation since they may be a reflection of circumstances beyond the control or influence of a disease control program. Communicable disease control programs should track trends in Class I(a), Class I(b) and Class II disease case rates at least on an annual basis and use this information in combination with other program activity measures in order to assess program performance and undertake program planning. Local health departments will be asked to demonstrate compliance with this process by either:

1) producing an annual report that includes disease case rates selected by the local health department and approved by the Department and is distributed to the public health and medical community; or

2) selecting on an annual basis at least three diseases of concern and providing a written interpretation of trends and a plan of action in response to those trends.

c) The local health department shall undertake the following activities, in accordance with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690), the Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693), and the AIDS Confidentiality and Testing Code (77 Ill. Adm. Code 697), in order to control the spread of, reduce the incidence of, and prevent Class I and Class II diseases within its jurisdiction.

1) Investigation shall be initiated on all reported cases (or suspected cases) of Class I(a) and (b) and Class II diseases: immediately (within 3 hours after receiving information about the suspected case) for Class I(a); within 24 hours for Class I(b); and within 7 days for Class II diseases.

2) For reported cases involving HIV or sexually-transmitted diseases, counseling shall be provided to a negotiated percentage of consenting investigated cases and (their) contacts.

3) For reported cases involving HIV or sexually-transmitted diseases, partner notification services shall be provided to a negotiated percentage of consenting investigated cases and (their) contacts.

4) For reported cases involving Tuberculosis and sexually-transmitted diseases, a negotiated percentage of

reported cases receiving treatment for infectious diseases shall complete the course of therapy included within a list of Department-approved guidelines for prevention and treatment of Tuberculosis and sexually-transmitted diseases.

5) For reported cases involving Tuberculosis and sexually-transmitted diseases, a negotiated percentage of identified contacts to cases shall be placed on, and complete, the course of preventive therapy included within a list of Department-approved guidelines for prevention and treatment of Tuberculosis and sexually-transmitted diseases.

6) Public health infectious disease clinics should be conducted in accordance with the United States Public Health Service's "Sexually Transmitted Diseases Clinical Practice Guidelines" (May 1991) or "Recommended Practices and Procedures for Providing Immunization Services" published by the Department and provided to local health departments.

7) A system to monitor the status of Class I(a) and (b) and Class II infectious diseases, including reporting, and a system to estimate the incidence, prevalence and demographic characteristics of cases that occur in the community shall be implemented and maintained.

8) Screening for Tuberculosis and HIV shall be conducted as determined by the results of a needs assessment of the community. If the needs assessment does not address this issue, goals for such screening shall be negotiated with the Department based upon a consideration of the current status of disease in the jurisdiction, resources (local, State, and federal) available to the local health department, and national ("Healthy People 2010") goals.

9) Ongoing immunization clinics shall be developed and maintained as a local service. Ongoing clinics should be of such number and frequency so as to provide for immunizations as recommended in "Recommended Practices and Procedures for Providing Immunization Services", and to assist schools to comply with Section 27-8.1 of the School Code [105 ILCS 5/27-8.1]. During outbreaks, special immunization clinics shall be provided, of such number and frequency as needed to control the spread of disease. Documentation shall be maintained regarding the clinics held by sites and dates; numbers immunized; and vaccine used or distributed by vaccine type, client ages, and the nature of the vaccinations, e.g., primary series or booster shot.

10) A plan shall be developed and implemented to survey the immunization status of the population in the local jurisdiction. The local health department shall assist and support the completion of annual surveys of selected populations, i.e., school enterers, special age groups or communities. Survey results should be used to plan and conduct activities to increase immunization levels to at least 90 percent for specific diseases. Subsequent surveys should show the same or higher levels of immunity.

11) Distribution and use of biologics provided by the Department shall be performed in accordance with the United States Public Health Service "Recommendations of the Advisory Committee on Immunization Practices (ACIP)" as published in "Standards for Pediatric Immunization Practices" (February 1993), United States Public Health Service "Sexually Transmitted Diseases Treatment Guidelines" (September 1989) or United States Public Health Service "Sexually Transmitted Diseases Clinical Practice Guidelines" (May 1991).

12) An accounting for biologics provided by the Department shall be reported monthly to the Department on

form IL482-00702.

13) Procedures shall be implemented that assure that the amount of State-supplied vaccine unaccounted for or wasted on an annual basis is less than 3 percent.

14) All known adverse events following administration of vaccines shall be investigated, and a Vaccine Adverse Events Reporting System (VAERS) form shall be completed and submitted to the Department.

15) Qualified personnel shall be available to conduct the activities pursuant to this Section. One or more staff members involved in infectious disease investigations shall complete the Centers for Disease Control and Prevention home study course on communicable disease control or equivalent approved by the Department within six months prior to conducting activities, and shall attend at least one related training program annually. This training program may include, but shall not be limited to, classroom training, satellite courses, or conference seminars.

16) Records that contain information that identifies or could lead to the identity of cases, case contacts, counseling clients, screening participants, or vaccine recipients shall be strictly confidential and shall not be released except as provided in applicable State and federal statutes and rules or with written consent of the person to whom the records related.

d) Notwithstanding activities conducted pursuant to subsection (c) of this Section, local health departments shall adhere to the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690), the Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693), and the AIDS Confidentiality and Testing Code (77 Ill. Adm. Code 697).

e) The percentages agreed upon between the Department and the local health department for activities described in subsection (c) of this Section shall be negotiated every three years to coincide with Local Health Protection Grant reviews and shall be based on current status of disease in the jurisdiction, resources (local, State, and federal) available to the local health department, federal initiatives and national ("Healthy People 2010") goals.

f) Documentation of activities conducted pursuant to this Section shall be maintained by the local health department for a minimum of five years after the completion of the grant period, and shall be available for review by the Department upon request.

(Source: Amended at 26 Ill. Reg. 421, effective January 1, 2002)

<General Materials (GM) - References, Annotations, or Tables>
77 ILAC § 615.300, 77 IL ADC 615.300

77 IL ADC 615.300
END OF DOCUMENT

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SUBPART C. PROGRAM STANDARDS

This document is current through June 12, 2009

615.310 Food Protection

a) In order to protect the citizens within its jurisdiction from contracting and transmitting foodborne diseases, the local health department shall conduct a comprehensive food protection program.

b) The local health department shall undertake the following activities to identify, reduce, and whenever possible, eliminate factors which may cause foodborne illnesses in order to reduce the incidence of foodborne illnesses.

1) Programs shall be conducted in accordance with a local ordinance that incorporates by reference or includes provisions at least as stringent as the Department's Food Service Sanitation Code and Retail Food Store Sanitation Code (77 Ill. Adm. Code 750 and 760) and includes enforcement authority, or in accordance with a written agreement with the Department which designates the local health department as an agent of the Department.

2) Current listings of all food service establishments and retail food stores as defined in the Food Service Sanitation Code or the Retail Food Store Sanitation Code shall be identified and maintained.

3) For each facility, the local health department shall assess the relative risks of causing foodborne illness; classify each facility as category I, category II, category III; and annually verify the classification of each facility.

A) "A Category I facility" is a food establishment that presents a high relative risk of causing foodborne illness based on the large number of food handling operations typically implicated in foodborne outbreaks and/or the type of population served by the facility. The following criteria shall be used to classify facilities as Category I facilities:

i) whenever cooling of potentially hazardous foods occurs as part of the food handling operations at the facility;

ii) when potentially hazardous foods are prepared hot or cold and held hot or cold for more than 12 hours before serving;

iii) if potentially hazardous foods which have been previously cooked and cooled must be reheated;

iv) when potentially hazardous foods are prepared for off-premises service for which time-temperature requirements during transportation, holding and service are relevant;

v) whenever complex preparation of foods, or extensive handling of raw ingredients with hand contact for ready-to-eat foods, occurs as part of the food handling operations at the facility;

vi) if vacuum packaging and/or other forms of reduced oxygen packaging are performed at the retail level; or

vii) whenever serving immunocompromised individuals, where these individuals comprise the majority of the consuming population.

B) A "Category II facility" is a food establishment that presents a medium relative risk of causing foodborne illness based upon few food handling operations typically implicated in foodborne illness outbreaks. The following criteria shall be used to classify facilities as Category II facilities:

i) If hot or cold foods are not maintained at that temperature for more than 12 hours and are restricted to same day service;

ii) If preparing foods for service from raw ingredients uses only minimal assembly; and

iii) foods served at an establishment that require complex preparation (whether canned, frozen, or fresh prepared) are obtained from approved food processing plants, (high risk) food service establishments or retail food stores.

C) A "Category III facility" is a food establishment that presents a low relative risk of causing foodborne illness based upon few or no food handling operations typically implicated in foodborne illness outbreaks. The following criteria shall be used to classify facilities as Category III facilities:

i) only pre-packaged foods are available or served in the facility, and any potentially hazardous foods available are commercially pre-packaged in an approved food processing plant;

ii) only limited preparation of non-potentially hazardous foods and beverages, such as snack foods and carbonated beverages, occurs at the facility; or

iii) only beverages (alcoholic or non-alcoholic) are served at the facility.

D) The Department recognizes that the local health department's experience with a facility is an important factor in assessing the relative risk of foodborne illness for the public. A local health department may reclassify a facility based upon its experience with the facility (e.g., inspection history, number and frequency of violations and their severity, corrective action, etc.) if, in its opinion, a health hazard will not result from such reclassification or such reclassification will provide better protection for the public. The basis for this decision must be documented and be available for Department inspection.

4) Facilities shall be inspected at least as often as prescribed by the following schedule. Inspections of all facilities shall include Hazard Analysis Critical Control Point (HACCP) concepts in accordance with Section 750.10 of the Food Service Sanitation Code.

A) Category I facilities shall receive three inspections per year, or two inspections per year if one of the following conditions is met:

i) a certified food service manager is present at all times the facility is in operation; or

ii) employees involved in food operations receive a HACCP training exercise, in-service training in another food service sanitation area, or attend an educational conference on food safety or sanitation.

B) Category II facilities shall receive one inspection per year.

C) Category III facilities shall receive one inspection every two years.

5) Plan reviews and pre-operational inspections shall be conducted, as appropriate, for new and extensively remodeled facilities.

6) Follow-up inspections, consultation and enforcement actions shall be conducted as necessary to ensure correction of deficiencies and violations of applicable ordinances, agreements, or rules.

7) A surveillance and control system shall be established to monitor, identify and record instances of foodborne disease; to detect sources of contamination; to establish factors that contribute to outbreaks; and to recommend preventive and control measures and take appropriate action to prevent further spread of disease. Hazardous food shall be identified and its distribution shall be restricted in accordance with procedures that include the following:

A) identification of and prohibition against foods that are unsafe and pose a potential threat to health and safety;

B) hold or embargo authority, criteria for destruction of adulterated or contaminated foods, and notification of recalls;

C) investigation of facilities upon receipt of complaints following events such as fire, natural disaster, and other occurrences which may compromise food safety; and

D) establishment of a system to encourage community reporting of foodborne illness to the local health department, which will notify the Department within 24 hours of occurrence.

8) Information shall be provided to the general public concerning prevention of foodborne illness and describing proper ways for storing, preparing, canning, preserving, and serving food. Information shall be made available to primary and secondary schools to instruct children regarding food sanitation and personal hygiene as it relates to food safety.

9) A program, which is designed especially for food establishment managers and personnel, shall be provided which describes the proper ways of storing and preparing food and the necessity for reporting illness.

10) Self-evaluation/quality assurance reviews shall be conducted annually to determine compliance with this Section and to evaluate the effectiveness of food protection activities within the jurisdiction of the local health department.

11) A written report of the self-evaluation/review shall be prepared and submitted to the Department annually and shall include the following:

A) number and percent of facilities having operations that frequently contribute to foodborne disease outbreaks (i.e., Category I facilities);

B) number and percent of facilities with identified factors or violations that could contribute to foodborne disease outbreaks;

C) average number of factors or violations per food establishment which could contribute to foodborne illness.

c) Qualified personnel shall be available for the local health department to conduct activities pursuant to this Section.

1) At least one supervisor or training officer shall be standardized and certified biennially in food safety practices and food sanitation by the United States Food and Drug Administration (FDA) certified State Evaluation Officers.

2) New program staff shall complete either a Department-provided or Department-approved initial orientation and training program during the first year of employment.

3) All personnel shall attend at least five hours of Department-approved training each year. Attendance at either a Department-provided or Department-approved orientation and training program, as required in subsection (c)(2) of this Section, shall fulfill this requirement for the year of attendance.

d) Documentation of activities conducted pursuant to this Section shall be maintained by the local health department for a minimum of five years after the completion of the grant period, and shall be available for review by the Department upon request.

(Source: Amended at 26 Ill. Reg. 421, effective January 1, 2002)

<General Materials (GM) - References, Annotations, or Tables>
77 ILAC § 615.310, 77 IL ADC 615.310

77 IL ADC 615.310
END OF DOCUMENT

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SUBPART C. PROGRAM STANDARDS

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615.320 Potable Water Supply

a) In order to protect the people within its jurisdiction from contracting and transmitting waterborne disease, the local health department shall establish a program to assure provision of safe, potable supplies of water for drinking, culinary, and sanitary purposes. The focus of this potable water supply program shall be non-community, semi-private and private water supplies; however, during a water emergency requiring public notice, the local health department should assure provision of potable water for all of its constituents.

b) The following activities shall be provided by the local health department to ensure an effective potable water supply program:

1) The potable water supply program shall be conducted pursuant to a local ordinance that incorporates by reference the Illinois Water Well Construction Code (77 Ill. Adm. Code 920) and the Illinois Water Well Pump Installation Code (77 Ill. Adm. Code 925) and includes enforcement authority, or pursuant to a written agreement with the Department which designates the local health department as an agent of the Department.

2) Current listings of names and addresses of all non-community public water supplies shall be maintained, and the Department shall be notified on forms provided by the Department within 30 days after the date the local health department becomes aware of any address or ownership changes.

3) A routine water sampling program shall be established and maintained for all non-community public water supplies in accordance with the Drinking Water Systems Code (77 Ill. Adm. Code 900).

4) All non-community public water supplies which have been originally surveyed shall be inspected and sampled at least every two years. A copy of all completed inspection reports indicating results of samples collected at the time of inspection and results of all samples collected since the last inspection, along with Department data forms, shall be forwarded to the Department within 14 days after completion of an inspection.

5) The owner of any non-community public water supply that is not in conformance with the construction, location, and operational (including sampling) requirements of the Drinking Water Systems Code shall be notified of the violations and ordered to correct them within a specified time. At the end of this time, a re-inspection shall be made to ensure that all violations have been corrected. If they have not been corrected, enforcement action shall commence.

6) All requests for inspection or sampling pertaining to any existing semi-private or private water supply un-

der the local health department's jurisdiction shall be evaluated regarding its public health significance. Requests determined to have a valid public health purpose shall be inspected within 7 days and a written report shall be made, as follows:

A) Semi-private water supplies shall be inspected and sampled upon request of the owner or occupant. The owner and occupant shall be informed of the results of the inspection and any sample analyses. If the water supply is not in conformance with the Public Area Sanitary Practice Code (77 Ill. Adm. Code 895) the owner shall be notified of the violations and ordered to correct them within a specified time. At the end of this time, a reinspection shall be made to ensure that all violations have been corrected. If they have not been corrected, enforcement action shall commence.

B) Existing private water supplies shall be inspected and sampled upon request of the owner, who shall be informed of the results of the inspection, interpretation of sample analyses, and recommended measures to correct all problems or violations of the Illinois Water Well Construction Code, Surface Source Water Treatment Code (77 Ill. Adm. Code 930) or the Illinois Water Well Pump Installation Code.

7) A permit shall be issued prior to the construction of any new water well, after review and determination that the application and proposed construction are in compliance with the Illinois Water Well Construction Code or approved ordinance. A permit to construct a well to serve a non-community public water system shall be issued by the local health department. Copies of the plans, the water well permit, and the water well construction log shall be submitted to the Department. The Department administers the permit program for all other aspects of the non-community system, as required in the Drinking Water Systems Code.

8) Inspection of new water wells.

A) At least one inspection of all new water wells for which a permit has been issued shall be conducted.

B) In addition, annually at least one well constructed by each licensed contractor installing wells in the jurisdiction shall receive a comprehensive inspection at the time of construction to assure that proper materials and construction methods are being used in accordance with the Illinois Water Well Construction Code and the Illinois Water Well and Pump Installation Code. This inspection shall include observation of the critical aspects of construction and shall include at a minimum inspection of grouting, setting of the casing, and installation of the pitless adapter.

C) A sample shall be collected from all new potable water wells, unless the local health department ensures that the homeowner or his agent will collect and submit a sample to a certified laboratory. The owner shall be informed of the results of the inspection, interpretation of sample analyses, and recommended measures to correct all problems or violations of the Illinois Water Well Construction Code, the Surface Source Water Treatment Code, or the Illinois Water Well Pump Installation Code. All violations shall be corrected or enforcement action shall be initiated. If the water sample contains any coliform bacteria or a nitrate concentration of 10 or more milligrams per liter as nitrogen, the local health department shall suggest additional sampling or other measures in writing to the homeowner to remedy the problem.

9) Information concerning water sampling; design, construction and operation of water supplies; and hazards of cross-connections shall be provided to the public upon request. Such education may be in the form

of oral presentations or may include the distribution of materials provided by the Department or by the local health department concerning these topics.

10) Written variances shall be issued for all private, semi-private, and non-community public water supplies in accordance with variance requirements of the applicable rules of the Department, and a copy of the variance that includes the rationale for any variance shall be submitted to the Department on a quarterly basis.

11) Sealing of abandoned wells.

A) Property owners shall be advised of the requirements and need for proper sealing of abandoned wells. When a new well is being constructed to replace an existing well, this advice may be provided to the property owner by the licensed well driller.

B) A representative of the local health department shall be present at the site at the time a well is being sealed by a homeowner, and shall annually be present at the site during at least three well sealings performed by each licensed well driller sealing wells in his/her jurisdiction to assure that proper materials and methods are used to seal abandoned wells in accordance with the Illinois Water Well Construction Code. A representative of the local health department shall observe the critical elements of the well sealing, which shall include placement of the sealing material and removal of the pumps and upper casing and assure that proper materials and placement methods are utilized. Where a licensed well drillers seals less than three wells, a representative of the local health department shall be present at all well sealings performed by that licensed driller.

C) If a well is sealed without the local health department being notified in advance, a warning letter shall be sent to the homeowner or licensed well driller and a follow-up inspection shall be conducted to ensure the well was sealed. Continued violations shall result in enforcement action or be referred to the Department for license suspension.

12) Within 30 days after the local health department receives the well construction report, the well permit application and construction report shall be submitted to the Illinois State Water Survey. Well sealing forms should also be submitted to the Survey within 30 days after they are received by the local health department.

13) Any person who has drilled a water well within the jurisdiction of the local health department without being properly licensed in accordance with the Illinois Water Well Contractors Licensing Act [225 ILCS 245] shall be referred to the Department. The local health department shall also provide the Department with a copy of correspondence to any well driller or pump installer concerning violations of the Illinois Water Well Construction Code and the Illinois Water Well Pump Installation Code.

14) A disease surveillance system that monitors and identifies instances of waterborne disease, detects sources of contamination, establishes factors that contribute to outbreaks, recommends preventive and control measures and takes appropriate action to prevent further spread of disease shall be established. The system shall promote notification of waterborne illness to the local health department, which in turn shall notify the Department within 24 hours.

c) Qualified personnel shall be available to conduct activities pursuant to this Section.

1) New program staff shall complete a Department provided initial orientation and training program during the first year of employment.

2) All personnel shall attend at least three hours of Department approved training annually.

d) Documentation of activities conducted pursuant to this Section shall be maintained by the local health department for a minimum of five years after the completion of the grant period, and shall be available for review by the Department upon request.

(Source: Amended at 26 Ill. Reg. 421, effective January 1, 2002)

<General Materials (GM) - References, Annotations, or Tables>
77 ILAC § 615.320, 77 IL ADC 615.320

77 IL ADC 615.320
END OF DOCUMENT

Westlaw

77 IL ADC 615.330
77 Ill. Adm. Code 615.330
Ill. Admin. Code tit. 77, § 615.330

WEST'S ILLINOIS ADMINISTRATIVE CODE
TITLE 77: PUBLIC HEALTH
CHAPTER I(1): DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER H: LOCAL HEALTH DEPARTMENTS
PART 615: LOCAL HEALTH PROTECTION GRANT RULES
SUBPART C. PROGRAM STANDARDS

This document is current through June 12, 2009

615.330 Private Sewage Disposal

a) In order to protect the people within its jurisdiction, the local health department shall establish a program to prevent the transmission of disease organisms, environmental contamination, and nuisances resulting from improper handling, storage, transportation and disposal of sewage from private sewage disposal systems.

b) The following activities shall be provided by the local health department to ensure an effective private sewage disposal program:

1) The program shall be conducted pursuant to a local ordinance that incorporates by reference or includes provisions at least as stringent as the Private Sewage Disposal Code (77 Ill. Adm. Code 905) and includes enforcement authority, or pursuant to a written agreement with the Department which designates the local health department as an agent of the Department.

2) In coordination with appropriate State and local agencies, long and short range plans should be developed to guide private sewage disposal system use for the protection of the environment and protection of the health of the people within its jurisdiction.

3) For all land platted after January 1, 1998, all subdivision plats which are to utilize private sewage disposal systems shall be reviewed and approved.

4) All new, altered, repaired or replaced private sewage disposal systems shall be reviewed and approved prior to construction as provided in the Private Sewage Disposal Code or in local ordinances.

5) Inspections adequate to confirm that systems conform to application plans and specifications shall be conducted of all private sewage disposal system installations. An inspection form with a drawing of the system shall be completed.

6) To ensure that septage within the local health department's jurisdiction is properly transported, stored and disposed of, an annual evaluation of all septage hauling equipment, storage facilities and land disposal sites shall be conducted.

7) Complaints of improper private sewage disposal shall be investigated within 10 working days.

8) When deficiencies have been identified, voluntary compliance shall be sought in accordance with the ordinance or agreement.

9) Continued noncompliance shall result in enforcement action in accordance with the ordinance or agree-

ment.

10) Educational materials regarding the proper handling and disposal of sewage shall be made available to the public upon request.

c) Qualified personnel shall be available to conduct activities pursuant to this Section.

1) New program staff shall complete a Department provided initial orientation and training program during the first year of employment.

2) All personnel shall attend at least three hours of Department approved training annually.

d) Documentation of activities conducted pursuant to this Section shall be maintained by the local health department for a minimum of five years after the completion of the grant period, and shall be available for review by the Department upon request.

<General Materials (GM) - References, Annotations, or Tables>

77 ILAC § 615.330, 77 IL ADC 615.330

77 IL ADC 615.330
END OF DOCUMENT

C

WEST'S ILLINOIS ADMINISTRATIVE CODE
TITLE 77: PUBLIC HEALTH
CHAPTER I(1): DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER K: COMMUNICABLE DISEASE CONTROL AND IMMUNIZATIONS
PART 690: CONTROL OF COMMUNICABLE DISEASES CODE
SUBPART D: DEFINITIONS

This document is current through June 19, 2009

690.900 Definition of Terms

For the purpose of this Part, the following shall be the accepted definitions of terms.

"Acceptable Laboratory" - A laboratory that is certified under the Centers for Medicare and Medicaid Services, Department of Health and Human Services, Laboratory Requirements (42 CFR 493), which implements the Clinical Laboratory Improvement Amendments of 1988 (42 USC 263).

"Act" - The Department of Public Health Act of the Civil Administrative Code of Illinois [20 ILCS 2305].

"Airborne Precautions" or "Airborne Infection Isolation Precautions" - Infection control measures designed to reduce the risk of transmission of infectious agents that may be suspended in the air in either dust particles or small particle aerosols (airborne droplet nuclei (5 <<mu>>m or smaller in size)) (see Section 690.1010(a)(7)).

"Authenticated Fecal Specimen" - A specimen is considered to be authenticated when a public health authority or a person authorized by a public health authority has observed one or more of the following:

The patient produce the specimen.

Conditions such that no one other than the case, carrier or contact could be the source of the specimen.

"Bioterrorist Threat or Event" - The intentional use of any microorganism, virus, **infectious** substance or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, **infectious** substance, or biological product, to cause death, **disease**, or other biological malfunction in a human, an animal, a plant or another living organism.

"Carrier" - A person or deceased person who harbors a specific **infectious** agent in the absence of discernible clinical **disease** and serves as a potential source of **infection** for others.

"Case" - Any person or deceased person having a recent illness due to a communicable **disease**.

"Confirmed Case" - A case that is classified as confirmed per federal or State case definitions.

"Probable Case" - A case that is classified as probable per federal or State case definitions.

"Suspect Case" - A person whose medical history or symptoms suggest that he or she may have or may be developing a communicable disease and does not yet meet the case definition of a probable or confirmed

case.

"Certified Local Health Department" - A local health authority that is certified pursuant to Section 600.210 of the Certified Local Health Department Code (77 Ill. Adm. Code 600).

"Chain of Custody" - The methodology of tracking specimens for the purpose of maintaining control and accountability from initial collection to final disposition of the specimens and providing for accountability at each stage of collecting, handling, testing, storing, and transporting the specimens and reporting test results.

"Child Care Facility" - A center, private home, or drop-in facility open on a regular basis where children are enrolled for care or education.

"Cleaning" - The removal of visible soil (organic and inorganic material) from objects and surfaces; it normally is accomplished by manual or mechanical means using water with detergents or enzymatic products.

"Clinical Materials" - A clinical isolate containing the infectious agent or other material containing the infectious agent or evidence of the infectious agent.

"Cluster" - Two or more persons with a similar illness, usually associated by place or time, unless defined otherwise in Subpart C of this Part.

"Communicable Disease" - An illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal or inanimate source to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or the inanimate environment.

"Contact" - Any person known to have been associated sufficiently with a case or carrier of a communicable **disease** to have been the source of **infection** for that person or to have been associated sufficiently with the case or carrier of a communicable **disease** to have become **infected** by the case or carrier.

"Contact Precautions" - **Infection** control measures designed to reduce the risk of transmission of **infectious** agents that can be spread through direct contact with the patient or indirect contact with potentially **infectious** items or surfaces (see Section 690.1010(a)(7)).

"Contagious **Disease**" - An **infectious disease** that can be transmitted from person to person.

"Dangerously Contagious or **Infectious Disease**" - An illness due to a specific **infectious** agent or its toxic products that arises through transmission of that agent or its products from an **infected** person, animal or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or the inanimate environment, and may pose an imminent and significant threat to the public health, resulting in severe morbidity or high mortality.

"Decontamination" - A procedure that removes pathogenic microorganisms from objects so they are safe to handle, use or discard.

"Department" - Illinois Department of Public Health.

"Director" - The Director of the Department, or his or her duly designated officer or agent.

"Diarrhea" - The presence of 3 or more loose stools within a 24-hour period.

"Disinfection" - A process, generally less lethal than sterilization, that eliminates virtually all recognized pathogenic microorganisms, but not necessarily all microbial forms (e.g., bacterial spores).

"Droplet Precautions" - Infection control measures designed to reduce the risk of transmission of infectious agents via large particle droplets that do not remain suspended in the air and are usually generated by coughing, sneezing, or talking (see Section 690.1010(a)(7)).

"Emergency" - An occurrence or imminent threat of an illness or health condition that:

is believed to be caused by any of the following:

bioterrorism;

the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin;

a natural disaster;

a chemical attack or accidental release; or

a nuclear attack or incident; and

poses a high probability of any of the following harms:

a large number of deaths in the affected population;

a large number of serious or long-term disabilities in the affected population; or

widespread exposure to an **infectious** or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.

"Epidemic" - The occurrence in a community or region of cases of a communicable **disease** (or an outbreak) clearly in excess of expectancy.

"Fever" - The elevation of body temperature above the normal (typically **considered** greater than or equal to 100.4 degrees Fahrenheit).

"First Responder" - Those individuals who in the early stages of an incident are responsible for the protection and preservation of life, property, evidence, and the environment, including emergency response providers as defined in section 2 of the Homeland Security Act of 2002 (6 USC 101), as well as emergency management, public health, clinical care, public works, and other skilled support personnel (such as equipment operators) that provide immediate support services during prevention, response, and recovery operations.

"Food Handler" - A person who produces, prepares, packages or dispenses food or drink.

"Health Care Facility" - Any institution, building, or agency or portion thereof, whether public or private (for-profit or nonprofit) that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. This includes, but is not limited to: ambu-

latory surgical treatment centers, home health agencies, hospices, hospitals, end-stage renal disease facilities, long-term care facilities, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, residential treatment facilities, and adult day care centers.

"Health Care Provider" - Any person or entity who provides health care services, including, but not limited to, hospitals, medical clinics and offices, long-term care facilities, medical laboratories, physicians, pharmacists, dentists, physician assistants, nurse practitioners, registered and other nurses, paramedics, emergency medical or laboratory technicians, and ambulance and emergency workers.

"Health Care Worker" - Any person who is employed by (or volunteers his or her services to) a health care facility to provide direct personal services to others. This definition includes, but is not limited to, physicians, dentists, nurses and nursing assistants.

"Incubation Period" - The time interval between initial contact with an **infectious** agent and the first appearance of symptoms associated with the **infection.**

"**Infectious Disease**" - A **disease** caused by a living organism or other pathogen, including a fungus, bacteria, parasite, protozoan, prion, or virus. An **infectious disease** may, or may not, be transmissible from person to person, animal to person, or insect to person.

"Institution" - An established organization or foundation, especially one dedicated to education, public service, or culture, or a place for the care of persons who are destitute, disabled, or mentally ill.

"Isolation" - The physical separation and confinement of an individual or groups of individuals who are **infected** or reasonably believed to be **infected** with a contagious or possibly contagious **disease** from non-isolated individuals, to prevent or limit the transmission of the **disease** to non-isolated individuals.

"Isolation, Modified" - A selective, partial limitation of freedom of movement or actions of a person or group of persons **infected** with, or reasonably suspected to be **infected** with, a contagious or **infectious disease.** Modified isolation is designed to meet particular situations and includes, but is not limited to, the exclusion of children from school, the prohibition or restriction from engaging in a particular occupation or using public or mass transportation, or requirements for the use of devices or procedures intended to limit disease transmis- sion.

"Isolation Precautions" - Infection control measures for preventing the transmission of infectious agents, i.e., Standard Precautions, Airborne Precautions (also known as Airborne Infection Isolation Precautions), Contact Precautions, and Droplet Precautions (see Section 690.1010(a)(7)).

"Least Restrictive" - The minimal limitation of the freedom of movement and communication of a person or group of persons while under an order of isolation or an order of quarantine, which also effectively protects unexposed and susceptible persons from disease transmission.

"Local Health Authority" - The health authority (i.e., full-time official health department, as recognized by the Department) having jurisdiction over a particular area, including city, village, township and county boards of health and health departments and the responsible executive officers of such boards, or any person legally authorized to act for such health authority. In areas without a health department recognized by the Department, the local health authority shall be the Department.

"Medical Record" - A written or electronic account of a patient's medical history, current illness, diagnosis, details of treatments, chronological progress notes, and discharge recommendations.

"Observation" - The practice of close medical or other supervision of contacts in order to promote prompt recognition of infection or illness, but without restricting their movements.

"Observation and Monitoring" - Close medical or other supervision, including, but not limited to, review of current health status, by health care personnel, of a person or group of persons on a voluntary or involuntary basis to permit prompt recognition of infection or illness.

"Outbreak" - The occurrence of illness in a person or a group of epidemiologically associated persons, with the rate of frequency clearly in excess of normal expectations. The number of cases indicating presence of an outbreak is disease-specific.

"Premises" - The physical portion of a building or other structure and its surrounding area so designated by the Director of the Department, his authorized representative, or the local health authority.

"Public Health Order" - A written or verbal command, directive, instruction or proclamation issued or delivered by the Department or certified local health department.

"Quarantine" - The physical separation and confinement of an individual or groups of individuals who are or may have been exposed to a contagious disease or possibly contagious disease and who do not show signs or symptoms.

"Sensitive Occupation" - An occupation involving the direct care of others, especially young children and the elderly, or any other occupation so designated by the Department or the local health authority, including, but not limited to, health care workers and child care facility personnel.

"Sentinel Surveillance" - A means of monitoring the prevalence and/or incidence of infectious disease or syndromes through reporting of cases, suspected cases, or carriers or submission of clinical materials by selected sites.

"Specimens" - Include, but are not limited to, blood, sputum, urine, stool, other bodily fluids, wastes, tissues, and cultures necessary to perform required tests.

"Standard Precautions" - Infection prevention and control measures that apply to all patients regardless of diagnosis or presumed infection status (see Section 690.1010(a)(7)).

"Sterilization" - The use of a physical or chemical process to destroy all microbial life, including large numbers of highly resistant bacterial endospores.

"Susceptible (non-immune)" - A person who is not known to possess sufficient resistance against a particular pathogenic agent to prevent developing infection or disease if or when exposed to the agent.

"Syndromic Surveillance" - Surveillance using health-related data that precede diagnosis and signal a sufficient probability of a case or an outbreak to warrant further public health response.

"Tests" - Include, but are not limited to, any diagnostic or investigative analyses necessary to prevent the

spread of disease or protect the public's health, safety, and welfare.

"Transmission" - Any mechanism by which an infectious agent is spread from a source or reservoir to a person, including direct, indirect, and airborne transmission.

"Voluntary Compliance" - Deliberate consented compliance of a person or group of persons that occurs at the request of the Department or local health authority prior to instituting a mandatory order for isolation, quarantine, closure, physical examination, testing, collection of laboratory specimens, observation, monitoring, or medical treatment pursuant to this Subpart.

(Source: Amended at 32 Ill. Reg. 3777, effective March 3, 2008)

<General Materials (GM) - References, Annotations, or Tables>
77 ILAC § 690.900, 77 IL ADC 690.900

77 IL ADC 690.900
END OF DOCUMENT

C

WEST'S ILLINOIS ADMINISTRATIVE CODE
TITLE 77: PUBLIC HEALTH
CHAPTER I(1): DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER K: COMMUNICABLE DISEASE CONTROL AND IMMUNIZATIONS
PART 690: CONTROL OF COMMUNICABLE DISEASES CODE
SUBPART E: GENERAL PROCEDURES

This document is current through June 19, 2009

§90.1000 General Procedures for the Control of Communicable **Diseases**

The purpose of this Subpart is to establish routine measures for the control of communicable **diseases** by the Department or local health authorities and health care providers. This Subpart establishes progressive initiatives to ensure that **disease**-appropriate measures are implemented to control the spread of communicable **diseases.** These procedures are intended for use in homes and similar situations. This Subpart does not apply to Sexually Transmissible **Diseases.** Sexually Transmissible **Diseases** are regulated under 77 Ill. Adm. Code 693.

a) Investigation.

1) *The Department of Public Health shall investigate the causes of* contagious, or *dangerously* contagious, or ***infectious diseases,*** *especially when existing in epidemic form, and take means to restrict and suppress the same, and whenever such* ***disease*** *becomes, or threatens to become, epidemic in any locality and the local board of health or local authorities neglect or refuse to enforce efficient measures for its restriction or suppression or to act with sufficient promptness or efficiency, or whenever the local board of health or local authorities neglect or refuse to promptly enforce efficient measures for the restriction or suppression of dangerously contagious or infectious diseases, the Department of Public Health may enforce such measures as it deems necessary to protect the public health, and all necessary expenses so incurred shall be paid by the locality for which services are rendered.* (Section 2(a) of the Act)

2) Each case or cluster of a reportable communicable **disease** shall be investigated to determine the source, where feasible. Findings of the investigation shall be reported as specified under the Section of this Part applicable to each specific **disease**.

3) The Department or local health authority may investigate the occurrence of cases, suspected cases, or carriers of reportable **diseases** or unusual **disease** occurrences in a public or private place for the purposes of verifying the existence of **disease**; ascertaining the source of the **disease**-causing agent; identifying unreported cases; locating and evaluating contacts of cases and suspected cases; identifying those at risk of **disease**; determining necessary control measures, including isolation and quarantine; and informing the public if necessary.

4) When the Director determines that a certain **disease** or condition that is known or suspected to be communicable or **infectious** warrants study, the Director may declare the **disease** or condition to be the subject of a medical investigation and require hospitals, physicians, health care facilities, etc., to submit such information, data and reports, and allow review and examination of medical records as are necessary for the purpose of the specific study. No such practitioner or person shall be liable in any action at law for

permitting such examination and review. The data so obtained shall be held confidential in accordance with the Communicable Disease Report Act [745 ILCS 45].

5) When cases of reportable infectious disease occur in any business, organization, institution or private home, the business owner, the person in charge of the establishment, or the homeowner shall cooperate with public health authorities in the investigation, including, but not limited to, release of food preparation methods, menus, customer lists, environmental specimens, food specimens, clinical specimens and the name and other pertinent information about employees or guests diagnosed with a communicable **disease** as the information relates to an **infectious disease** investigation.

6) When two or more cases of a reportable communicable **disease** occur in association with a common source, the investigation should include a search for additional cases.

7) The Department may conduct sentinel surveillance for an **infectious disease** or syndrome, other than those **diseases** or syndromes for which general reporting is required under this Part, if the Department determines that sentinel surveillance will provide adequate data for the purpose of preventing or controlling **disease** or achieving other significant public health purposes. The Department shall select, after consultation with the sites, sentinel surveillance sites that have epidemiological significance for the **disease** or syndrome under investigation. A **disease** or syndrome may be removed from sentinel surveillance if the Department determines that the surveillance is no longer necessary. The Department shall provide a description, in writing, to sentinel surveillance sites of a specific, planned mechanism for surveillance of the disease or syndrome and/or submission of clinical materials from cases and suspect cases.

8) Investigations of outbreaks shall be summarized in a final report and submitted to the Department. The most current summary form shall be used, and a narrative report may also be requested.

9) Investigations conducted by the Department or local health authority may include, but are not limited to:

A) Review of pertinent, relevant medical records by authorized personnel, if necessary to confirm the diagnosis; to investigate causes; to identify other cases related to the outbreak or the reported dangerously contagious or **infectious disease** in a region, community, or workplace; to conduct epidemiologic studies; to determine whether a patient with a reportable dangerously contagious or **infectious disease** has received adequate treatment to render the patient non-**infectious** or whether a person exposed to a case has received prophylaxis, if appropriate. Review of records may occur without patient consent and shall be conducted at times and with such notice as is possible under the circumstances;

B) Performing interviews with the case or persons knowledgeable about the case to collect pertinent and relevant information about the causes of or risk factors for the reportable condition;

C) Medical examination and testing of persons, with their explicit consent;

D) Obtaining, from public or private businesses or institutions, the identities of and locating information about persons, travelers, passengers, or transportation crews with a similar or common potential exposure to the infectious agent as a reported case; such exposure may be current or have occurred in the past;

E) Interviewing or administering questionnaire surveys confidentially to any resident of any community,

or any agent, owner, operator, employer, employee, or client of a public or private business or institution, who is epidemiologically associated either with the outbreak or with the reported dangerously contagious or infectious disease case or has had a similar exposure as a reported case;

F) Collecting environmental samples of substances or measurements of physical agents that may be related to the cause of an outbreak or reportable dangerously contagious or infectious disease;

G) Taking photographs related to the purpose of the investigation. If the photographs are taken in a business, the employer shall have the opportunity to review the photographs taken or obtained for the purpose of identifying those that contain or might reveal a trade secret; and

H) Entering a place of employment for the purpose of conducting investigations of those processes, conditions, structures, machines, apparatus, devices, equipment, records, and materials within the place of employment that are relevant, pertinent, and necessary to the investigation of the outbreak or reportable dangerously contagious or infectious disease. Investigations shall be conducted during regular business hours, if possible, and with such notice as is possible under the circumstances.

b) Control of Food Products. Whenever a case, a carrier, or a suspected case or carrier of the following diseases exists in a home or establishment where food is produced that is likely to be consumed raw or handled after pasteurization and before final packaging, the sale, exchange, removal or distribution of the food items from the home or establishment may be prohibited as deemed necessary by the Department or the local health authority to prevent the transmission of communicable diseases.

1) Cholera

2) Cryptosporidiosis

3) Diphtheria

4) E. coli infections (Shiga toxin-producing E. coli, Enterotoxigenic E. coli, Enteropathogenic E. coli and Enteroinvasive E. coli)

5) Foodborne or waterborne illness

6) Giardiasis

7) Hepatitis A

8) Norovirus

9) Salmonellosis

10) Shigellosis

11) Smallpox

12) Staphylococcal skin **infections**

13) Streptococcal **infections**

14) Typhoid fever

15) Yersiniosis

c) Schools, Child Care Facilities, and Colleges/Universities.

1) Except in an emergency, the occurrence of a case of a communicable **disease** in a school, child care facility or college/university should not be **considered** a reason for closing of the school, facility or college/university.

2) Persons suspected of being **infected** with a reportable **infectious disease** for which isolation is required, or persons with diarrhea believed to be **infectious** in nature, shall be refused admittance to the school or child care facility while acute symptoms are present.

3) School, child care facility, and college/university authorities shall handle contacts of **infectious disease** cases in the manner prescribed in this Part, or as recommended by the local health authority.

d) Release of Specimens.

1) Whenever this Part requires the submission of laboratory specimens for release from imposed restrictions, the results of the examinations will not be accepted unless the specimens have been examined in the Department's laboratory or an acceptable laboratory. The number of specimens needed for release, as detailed under specific diseases, is the minimum and may be increased when deemed necessary by the Department.

2) The local health authority may require testing of foodhandlers for specific pathogens, including, but not limited to, Norovirus, as deemed necessary in response to an outbreak.

(Source: Amended at 32 Ill. Reg. 3777, effective March 3, 2008)

<General Materials (GM) - References, Annotations, or Tables>
77 ILAC § 690.1000, 77 IL ADC 690.1000

77 IL ADC 690.1000
END OF DOCUMENT

Westlaw

77 IL ADC 615.340
77 Ill. Adm. Code 615.340
Ill. Admin. Code tit. 77, § 615.340

WEST'S ILLINOIS ADMINISTRATIVE CODE
TITLE 77: PUBLIC HEALTH
CHAPTER I(1): DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER H: LOCAL HEALTH DEPARTMENTS
PART 615: LOCAL HEALTH PROTECTION GRANT RULES
SUBPART C. PROGRAM STANDARDS

This document is current through June 12, 2009

615.340 Common Requirements

a) All activities performed under this Part shall be governed in all respects by the laws of the State of Illinois. Personnel performing the programs described in this Subpart shall meet the applicable requirements of the Medical Practice Act of 1987 [225 ILCS 60]; the Nursing and Advanced Practice Nursing Act [225 ILCS 65]; and the Environmental Health Practitioner Licensing Act [225 ILCS 37].

b) All local health departments shall maintain a 24-hour notification system that IDPH, hospitals, or members of the general public can contact to promptly reach a staff person to report a suspect or actual public health incident or event. Local health departments must document, at least quarterly, the method used to ensure the operational reliability of this 24-hour notification system. In addition, local health departments shall document and provide to the IDPH Emergency Officer and their IDPH Regional Health Officer the procedure that IDPH, hospitals or members of the general public must utilize to activate this 24-hour notification system.

c) All local health departments are required to maintain a current, all hazard emergency response/disaster plan for their jurisdiction. "All hazard" includes, but is not limited to, natural, technological and intentionally caused emergency events, including disease outbreaks, bioterrorism, floods, severe weather, environmental and food protection incidents and others. All local health departments shall electronically submit to the Department the plan for their jurisdiction. Any and all future amendments to the plan shall be electronically submitted to the Department immediately. All local health departments shall keep a copy of the plan on file in their principal office. The Department will review each plan once at least every three years, or as often as necessary, as part of the local health department's program review process conducted in accordance with Section 615.220. The emergency response/disaster plan will provide a framework for response operations of the local health department or multi-jurisdiction, and will outline specific actions for local response and recovery activities. The plan will provide guidance for the local health department's primary programs to support jurisdiction-wide emergency operations and prescribe, among other items, the availability of personnel and response needs and provisions. The following items are minimum elements of an approved emergency response/disaster plan:

1) procedure for 24-hour availability of the local health department to receive information on a significant or potential emergency situation from the general public or a federal, State or local governmental agency;

2) procedure for internal notification ("call-tree") to alert key staff within the local health department of an emergency situation;

3) procedure that details how and when the local health department will contact the local emergency management agency, local law enforcement agency and the Department of an emergency situation;

4) procedure that will outline the rapid mobilization of non-essential staff of the local health department to assist with the emergency situation, including the identification of critical programs administered by the local health department;

5) procedure for the dissemination of information to first responders, local health care providers, hospitals, clinics and pharmacies within the jurisdiction to alert them of a significant or potential emergency situation; and

6) procedure for the implementation of a mass vaccination and prophylaxis and treatment distribution/management of stockpiles of pharmaceuticals in response to a significant or potential communicable disease situation within the jurisdiction.

d) The local health department shall submit information annually on forms provided by the Department concerning activities conducted in each program conducted by the local health department. This local health protection grant program statistical information for food protection, potable water supply, and private sewage disposal programs shall include information for a calendar year and annually shall be submitted to the Department by March 1, following December 31 of the year for which information is being reported. The first annual reports will be due by March 1, 2004, for the year ending December 31, 2003. Annual reporting for infectious disease control programs shall be conducted in accordance with Section 615.300.

(Source: Amended at 28 Ill. Reg. 12030, effective August 3, 2004)

<General Materials (GM) - References, Annotations, or Tables>
77 ILAC § 615.340, 77 IL ADC 615.340

77 IL ADC 615.340
END OF DOCUMENT

Invoice Number:	0905
Date of Invoice:	June 3, 2009
Billing Period:	April-09

To:

Champaign County Public Health Department
Att'n.: Evelyn Boatz
1776 East Washington Street
Urbana, Illinois 61802

For the Following Expenses:

533.07 Professional Services - Infectious Disease Prevention & Mgmt	$	6,436.00
533.07 Professional Services - Maternal Child Health Mgmt	$	3,127.58
533.07 Professional Services - IBCCP & Clinical Services	$	2,053.58
533.07 Professional Services - Environmental Health	$	26,635.58
533.07 Professional Services - Administration	$	7,303.58
533.07 Professional Services - Bio-T Grant	$	4,695.92
533.07 Professional Services - TFC Grant	$	2,983.22
533.07 Professional Services - West Nile Virus Grant	$	586.71
533.07 Professional Services - Non-Community Water - CU Surveys	$	-
Total Amount Due to CUPHD per Contract	**$**	**53,822.17**

CERTIFICATION:
I hereby certify that the amounts billed above agree with the approved budget; that appropriate purchasing procedures have been followed, and that reimbursement has not previously been requested or received.

Authorized Agency Official

Illinois Association of Public Health Administrators

Public Health in Peril: The Call to Action

The Illinois Public Health Association
68th Annual Meeting and
Joint Conference with the
Illinois Association of Public Health Administrators and the
Northern Illinois Public Health Consortium

Pre-conference Survey Results

The Illinois Public Health Association (IPHA) conducted an online survey in March of the year 2009, to collect data on the public health community's perception of the state of public health, opportunities to strengthen the infrastructure, additional funding mechanisms, and feasibility of a unified advocacy agenda for public health in Illinois. The survey was circulated via email to IPHA membership lists, and to 68th annual meeting conference attendees.

A total of 190 respondents participated in the web based survey. *Of the 190 participants, 80% represent IPHA members, 17% are members of IAPHA, and 13% NIPHC members.*

This is the first survey IPHA has conducted in partnership with our allied health associations, the Northern Illinois Public Heath Consortium (NIPHC) and the Illinois Association of Public Health Administrators (IAPHA), and the beginning of a much needed dialogue on how to improve the public health system in Illinois. The results of the data analysis are summarized below in this report.

Focus in the Current Environment

- *47% of the respondents agree now is the time for Illinois Public Health Leaders to focus on public health excellence.*
- *When asked the best chance to get people to value the public health system, the respondents were split with 32% support a focus on showing the value of past investments on health, costs, quality of life, etc, 26% say to focus on social values, and 24% believe the focus should be on the promise of future health gains on top health concerns.*
- *When asked if we could only advocate for investments in one category, nearly 40% of the respondents agree the focus should on primary prevention services, followed by community health improvement planning (16%) and general infrastructure (14%).*

Support for Coordinated Advocacy

- *37% of the respondents agree that the biggest reason we have not achieved needed public health system investment is that advocates are splintered with too many different requests and messages.*

- *75% of respondents agree that it is essential to get all public health leaders to rally around 1-3 advocacy priorities.*

- *A majority of the survey participants (76%) disagreed that their respective associations should advocate alone rather than spend time on a unified agenda with other associations.*

- *71% of respondents believe that, if IAPHA, NIPHC, and IPHA all backed a set of advocacy priorities, it would attract other Illinois public health advocate groups, while 25% are unsure and 4% disagreed.*

- *90% of respondents would be willing to invest their time in a campaign to shore up Illinois public health systems if it brought their organization benefits, especially support for important policies (76%) followed by more money (49%) for their organization.*

- *When asked the most feasible and effective way to strengthen public health advocacy, the response was a three way split: 33% of the respondents say to activate the boards of health and encourage them to take the lead in public health advocacy; 30%, to mobilize "special interest health advocates" to create a common advocacy moment; and 29%, to secure funding for public health constituency development.*

Strengthening Public Health Systems

- *Nearly half (48%) believe the path to sustainable governmental public health funding is to re-think/reform the role of local public health, and ranking second (35%) is increasing state and local revenue sources. Less than 1% of respondents say we should cut services and concentrate efforts to match dwindling resources.*

- *68% of the respondent, believe that the local health protection grant should be expanded and refocused to include health promotion and to support implementation of IPLAN recommendations.*

- *39% of survey respondents believe that the most important step in improving the public health infrastructure in Illinois is to secure more funding for state and local public health. Studying the gaps between population health risks and our system capacity ranked second at 30%.*

- *43% agree that the most feasible and effective strategy for improving public health practice in Illinois should include all of the following: legislation to improve practice at the state and local level, Illinois public health accreditation, improved public health certification requirements, and periodic public health system assessments of the state and the local system.*

- *30% of respondents believe that the most feasible and effective way to build effective public health partnerships is to let them develop naturally around defined common interests, rather than through state IPLAN health committee membership requirements (17%), asking local governments to support partnerships (16%) or state legislation to institutionalize partnerships (11%).*

IPHA 68th Annual Meeting "Public Health in Peril - The Call to Action"

1. Now is the time for Illinois public health leaders to:

	Response Percent	Response Count
Hunker down and keep current services going as best we can	22.1%	42
Focus on public health excellence (e.g., quality, results, accreditation)	**47.4%**	**90**
Be bold with new policy campaigns	16.8%	32
Be bold in advocating for high-cost/high-reward system investments	4.7%	9
None of these	5.8%	11
Not sure	3.2%	6
	answered question	**190**
	skipped question	**0**

2. In Illinois, our best chance to get people to value the public health system is to focus on...

	Response Percent	Response Count
Peace of mind – personal protection from threats, security of a safety net	14.2%	27
Social values – compassion, eliminating disparities, equity	25.8%	49
Promise of future health gains on top health concerns	24.2%	46
Past results – show value of past investments on health, costs, quality of life, etc.	**32.1%**	**61**
None of these	1.6%	3
Not sure	2.1%	4
	answered question	**190**
	skipped question	**0**

3. In Illinois, the biggest reason we haven't achieved needed public health system investment is:

	Response Percent	Response Count
Not enough advocates for public health	15.3%	29
Advocates are splintered with too many different requests and messages	**37.4%**	**71**
We haven't offered good enough reasons to invest in public health systems	13.7%	26
We haven't committed to be accountable for results	8.9%	17
Not sure	7.9%	15
Other (please specify)	16.8%	32
	answered question	**190**
	skipped question	**0**

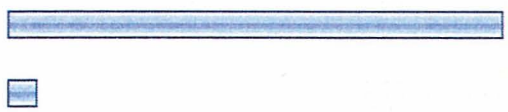
4. Right now, getting all Illinois public health leaders to rally around 1-3 advocacy priorities is...

	Response Percent	Response Count
Essential	**75.3%**	**143**
Somewhat important	17.4%	33
A waste of time	2.6%	5
Not sure	4.7%	9
	answered question	**190**
	skipped question	**0**

5. I would rather my association (IPHA, IAPHA, or NIPHC) advocate alone for my interests than spend time on a unified agenda with other associations.

	Response Percent	Response Count
True	8.4%	16
False	**76.3%**	**145**
Unsure	14.2%	27
Not applicable	1.1%	2
answered question		**190**
skipped question		**0**

6. If IAPHA, NIPHC, and IPHA all backed a set of advocacy priorities, it would attract other Illinois public health advocate groups to join.



	Response Percent	Response Count
True	**70.5%**	**134**
False	3.7%	7
Unsure	25.3%	48
Not applicable	0.5%	1
answered question		**190**
skipped question		**0**

7. I would be willing to invest my time in a campaign to shore up Illinois public health systems if it brought my organization more...(check all that apply)

	Response Percent	Response Count
Money	48.9%	93
Community recognition	34.7%	66
Skilled volunteers, donated services	27.4%	52
Support for important policies	**76.3%**	**145**
Not willing to invest my time in this right now	9.5%	18
answered question		**190**
skipped question		**0**

8. If we could only advocate for investments in one of the following, we should focus on:

	Response Percent	Response Count
Primary prevention services	**39.5%**	**75**
Data and information systems	7.4%	14
Community health improvement planning	15.8%	30
Policy	4.2%	8
Partnerships and coordination among many sectors	8.9%	17
Regional infrastructure	3.7%	7
Infrastructure in general	14.2%	27
Not sure	3.7%	7
Other (please specify)	2.6%	5
answered question		**190**
skipped question		**0**

9. The most likely path to sustainable governmental public health funding in Illinois is to...

	Response Percent	Response Count
Increase state and local revenue sources	34.7%	66
Cut services and concentrate our efforts to match dwindling resources	0.5%	1
Radically lower costs to deliver similar services	6.3%	12
Re-think/reform role of local public health	**47.9%**	**91**
Not sure	10.5%	20
	answered question	**190**
	skipped question	**0**

10. Should the local health protection grant be expanded and refocused to include health promotion and to support implementation of IPLAN recommendations?

	Response Percent	Response Count
Yes	**68.4%**	**130**
No	10.0%	19
Not sure	21.6%	41
	answered question	**190**
	skipped question	**0**

11. The most important step in improving the public health infrastructure in Illinois is:

	Response Percent	Response Count
Getting our house in order by designing a regional public health system	16.3%	31
Studying the gaps between population health risks and our system capacity	30.0%	57
Securing more funding for state and local public health	**38.9%**	**74**
Not sure	6.8%	13
Other (please specify)	7.9%	15
	answered question	**190**
	skipped question	**0**

12. The most feasible and effective strategy for improving public health practice in Illinois is:

	Response Percent	Response Count
Design public health legislation to improve practice at the state and local level	18.4%	35
Implement public health accreditation in Illinois	1.1%	2
Improve existing public health department certification requirements	5.8%	11
Conduct periodic public health system assessments of the state and the local system	11.1%	21
All of the Above	**43.2%**	**82**
Not sure	11.1%	21
Other (please specify)	9.5%	18
	answered question	**190**
	skipped question	**0**

13. The most feasible and effective way to build effective public health partnerships is to:

	Response Percent	Response Count
Institutionalize public health partnerships through state legislation	11.1%	21
Ask local governments to support public health partnerships	16.3%	31
Expand membership of the "health committee" that develops the IPLAN through the development of state requirements	16.8%	32
Let partnerships develop naturally around defined common interests	**30.0%**	**57**
Not sure	18.4%	35
Other (please specify)	7.4%	14
	answered question	**190**
	skipped question	**0**

14. The most feasible and effective way to strengthen public health advocacy is to:

	Response Percent	Response Count
Secure funding for public health constituency development	28.9%	55
Activate boards of health and encourage them to take the lead in public health advocacy	**33.2%**	**63**
Mobilize "special interest health advocates" to create a common advocacy moment.	29.5%	56
Other (please specify)	8.4%	16
	answered question	**190**
	skipped question	**0**

15. In which association(s) are you a member (check all that apply)?

	Response Percent	Response Count
IPHA	**79.5%**	**151**
IAPHA	17.4%	33
NIPHC	12.6%	24
None	13.2%	25
answered question		**190**
skipped question		**0**