CHAMPAIGN COUNTY BOARD OF HEALTH

Brookens Administrative Center
1776 E. Washington
Urbana, IL 61802

Phone: (217) 384-3772
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Champaign County Board of Health

Tuesday, May 25, 2010
6:00 p.m.
Lyle Shields Meeting Room
Brookens Administrative Center, 1776 E. Washington
Urbana, Illinois

AGENDA

ITEM		PAGE NO.
A.	**Call to Order**	
B.	**Roll Call**	
C.	**Approval of Agenda/Addenda**	
D.	**Approval of Minutes**	
	1. April 27, 2010	*1-7
E.	**Public Participation on Agenda Items Only**	
F.	**Correspondence and Communications**	
G.	**Smile Healthy**	
	1. Monthly Report	*8-10
H.	**CUPHD**	
	1. Approval of CUPHD Invoice – April 2010	*11
	2. Administrator's Report *(To Be Distributed)*	
	3. CUPHD Monthly Division Reports	
	Reports Can Be Viewed At: http://www.c-uphd.org/monthly-reports.html	
	a. Administrative Training	
	b. Environmental Health	
	c. Human Resources	
	d. Infectious Disease	
	e. Maternal & Child Health	
	f. Wellness & Health Promotion	
I.	**Illinois Public Health Association Consultant**	
	1. Reformation for the Future: Champaign County Board of Health Consulting Report & Presentation *(Separate Attachment)*	

J. Other Business

1. Election of Officers

K. Approval of Closed Session Minutes

1. April 27, 2010

L. Public Participation on Non-Agenda Items Only

M. Adjournment

CHAMPAIGN COUNTY BOARD OF HEALTH

Monthly Meeting
Tuesday, April 27, 2010

Call to Order

The Board of Health (BOH) held its monthly meeting on April 27, 2010 in the Lyle Shields Meeting Room at the Brookens Administrative Center, 1776 East Washington, Urbana. The meeting was called to order at 6:02 p.m. by Board President Julian Rappaport.

Roll Call

Board members present at the time of roll call were Brenda Anderson, Cherryl Ramirez, Mark Huls, Stan James, John Peterson, Julian Rappaport, Bobbi Scholze, and Betty Segal. The staff member present was Kat Bork (Board of Health Secretary).

The absent Board member was Prashanth Gowda, who had notified the President in advance that he would not attend the meeting.

Also present were Deb Busey (County Administrator), Carol Elliott (CUPHD Board Chair), Nancy Greenwalt (Smile Healthy Executive Director), Fred Grosser (CUPHD Legal Counsel), Jim Roberts (CUPHD Environmental Health Director), Jennifer Sampson (Crisis Nursery Family Specialist), and Andrea Wallace (CUPHD Finance Director).

Approval of Agenda/Addendum

MOTION by Scholze to approve the agenda and addendum; seconded by Huls.

Rappaport asked for the agenda packet to be amended with the removal of Pages 29-30 (the attachments for the Request to Approve Amendment to Appendix A of CUPHD/BOH Agreement). Busey requested Page 30 remain with the explanation that she and Julie Pryde developed this document with the intention that it serve as an appendix to the BOH/CUPHD agreement. Pryde was aware the document on Page 30 would be included in the April agenda packet for the BOH's approval. Rappaport agreed to change his request to only eliminate Page 29. James liked the format used in the decision memorandum and asked if the agenda could be amended to include the discussion and approval of the decision memorandum as the standard format to be used when changing contracts or policies. Busey stated there was no action item on the agenda or addendum to approve the decision memorandum format.

Rappaport requested the Crisis Nursery quarterly report on the Beyond Blue Program be moved from the addendum to after the Smile Healthy monthly report presentation. He further requested the CUPHD invoice be considered before the other CUPHD items.

Motion carried as amended with unanimous support.

Approval of Minutes

MOTION by Peterson to approve the March 30, 2010 minutes; seconded by Huls.

Peterson requested a correction to line 41. Rappaport requested the date on line 58 be changed to April 5th and a language alteration be made to line 178.

Motion carried as amended with unanimous support.

Public Participation on Agenda Items Only

There was no public participation on the agenda items.

Correspondence and Communications

There were no communications.

Smile Healthy

MOTION by James to receive and place on file the Smile Health monthly report for March 2010; seconded by Huls.

Greenwalt reported that waiting lists for restorative dental care have gotten longer in recent months. Rappaport inquired how the BOH's funding cut impacted that waiting list. Greenwalt explained the cut in funding was absorbed by limiting payments to private practices. Smile Healthy has stopped recruiting new providers. The cut prevented Smile Healthy from expanding services to include staff care days, wherein a doctor would bill Medicaid for the services rendered on that day. She estimated her scheduler could probably come up with 200 children in the county who need restorative care in addition to the 500 people on the Frances Nelson Health Center waiting list.

Huls asked how Smile Healthy bills public aid for dental services. Greenwalt said her organization bills Medicaid, families, and private insurance whenever they are able. Those with private insurance only receive an exam on mobile visits or school visits. She said 90% of the people they see are on Medicaid. Smile Healthy is only able to bill Medicaid if the dentists allow them to bill for services provided in private offices under the office's Medicaid numbers. That helps Smile Healthy recoup some of the costs. Most providers do not want to have anything to do with Medicaid.

Peterson asked how the organization was working with Frances Nelson. Greenwalt stated the mobile clinic program was expanded with an Illinois Children's Healthcare Foundation grant. They visited Frances Nelson to see a lot of kids on Medicaid and 100 adults with the assistance of a small grant. Smile Healthy works at Frances Nelson two days each month, one day primarily for kids and the other day primarily for adults. Greenwalt said Smile Healthy will continue to serve adults as long as grants pay for the service. All the patients must be internally referred from Frances Nelson. They are able to see 20 patients a day, but there are hundreds

more that need dental work. Peterson questioned if there had been any increase in activity by the Medicaid dental clinic in town. Greenwalt remarked Smile Healthy cannot refer patients to that clinic, but she is aware the clinic is busy. She further noted February was a big education month for children's oral health.

In response to Segal's question about the outcome of education efforts, Greenwalt explained Smile Healthy receives a grant to promote education and hygiene through Frances Nelson and Head Start. A hygienist developed the curriculum to work with Head Start schools. This includes tracking kids' behaviors over time with surveys. Other than Head Start, it is difficult to determine the impact of education when they do not see the same patients regularly.

Motion carried with unanimous support.

CUPHD

Administrator's Report – April 2010

The Administrator's April report was included in the agenda packet.

Local Health Departments Strategies Brief

The item was provided for information only.

CUPHD Monthly Division Reports – March 2010

The monthly division reports for Administrative Training, Environmental Health, Human Resources, Infectious Disease, Maternal & Child Health, and Wellness & Health Promotion were posted on CUPHD's website at http://www.c-uphd.org/monthly-reports.html.

Discussion Regarding CUPHD Monthly Division Reports

Rappaport explained that Julie Pryde requested the monthly division reports included in agenda packets. Rappaport wanted to obtain a consensus from the BOH regarding whether they preferred to read the division reports online or in the agenda packet in order to communicate this to Pryde. Including the reports in the agenda packet would create more expense in terms of staff time and paper supplies. Rappaport remarked he would like reports about the services the BOH is specifically funding.

Segal asked if any member lacked Internet access. James stated he only has Internet access at work and does not believe in taking work home with him. Segal asked if James could stay late at work to view the reports and James declined the suggestion. He noted monthly reports are not included in agenda packets for the County Board. The County departments' monthly reports are posted online or they can be viewed at Bork's office. James suggested the BOH receive some type of internal paper with the BOH packet only if there is a big change or increase to a program. Peterson spoke about the history of monthly reports and how the BOH has addressed the issue almost every year to try different options. Ramirez would prefer receiving a brief summary by email of a division report's major points, instead of a paper report.

She can go to the website to view the full reports for more detail. This is the approach she takes with her own board. The BOH discussed how to receive short reports focused on County activities. Scholze, noting Pryde had described her practice of communicating individually with the three-person CUPHD Board, suggested the division directors could provide bullet points for the monthly Administrator's Report to make it less labor intensive for Pryde. This would be a sufficient method of reporting any division highlights. Rappaport said they could ask Pryde to include in the Administrator's Report a brief summary of anything she thought the Board needed to be aware of or to provide an update on the divisions. The BOH concurred it would like highlights of division activities to be included in the Administrator's Report and declined receiving paper copies of the division reports.

Request to Approve the West Nile Virus Prevention Grant

MOTION by James to approve the application for and, if awarded, acceptance of the West Nile Virus Prevention Grant; seconded by Segal.

Rappaport asked where the specific action was requested by the Administrator. Bork and Busey explained the item was listed on the agenda using appropriate language to identify it as an action item for the Board's consideration. James stated the BOH needs to decide how to handle these issues until the Board sets a policy about the format for action items, such as a decision memorandum. He was in favor of using the decision memorandum, but until the BOH has a tool in place, the format used tonight was sufficient. He noted Pryde provided the grant information and the item was listed on the agenda in the same manner as action items on County Board agendas.

The BOH commented on the discussion held in March about how new grants would be presented and summary information about ongoing grants included in the Administrator's Report. Rappaport directed next month's agenda include an item to consider formally adopting a procedure for action items.

Peterson inquired how the $8,300 grant figure was determined. Roberts explained the state has a formula to calculate what a county receives for West Nile funding. He confirmed they were receiving the maximum grant amount possible and this year's funding was more than the previous year. This grant has been around for 10 years in similar forms and the pool of available money can vary. The BOH discussed the West Nile Virus history in Champaign County. Roberts added that CUPHD has a separate West Nile grant for $12,000-$14,000 based on the cities' combined population.

Motion carried with unanimous support.

Request to Approve Amendment to Appendix A of CUPHD/BOH Agreement

MOTION by James to add the amendment to Appendix A of the CUPHD/BOH Agreement; seconded by Ramirez. James requested a roll call vote.

Busey stated the actual amendment language was included in the agenda packet and the amendment document would be added to Appendix A. The County Auditor is interested making sure the change is appropriately documented.

Peterson objected to the "non-valid public health significance" language because he felt this service had valid public health significance. Roberts explained the Illinois Department of Public Health has a specific definition of valid public health significance regarding well water testing. Valid public health significance is interpreted as new well construction, illness in the family, or an infant in the family. Residents monitoring their own wells are not considered a valid public health reason using IDPH language. This language is used to comply with the program standards interpretation.

Segal stated there were two errors in the amendment. The title should contain the word "for" instead of "or" and the word "health" is misspelled in the first line. The BOH agreed with making the errata changes to the amendment. Rappaport thanked CUPHD for providing the modifications requested by BOH members. He asked for verification that the cost of providing this service would be borne by the individuals requesting the service and that the BOH would not be billed for these activities other than passing the fees through to CUPHD. Wallace stated CUPHD would bill the BOH based on actual costs. She hopes the fee CUPHD recommended will offset the actual costs. The fee will be reevaluated if it is not adequate to cover CUPHD's costs. The program should be cost neutral.

Motion carried with roll call vote of 8 to 0. Anderson, Huls, James, Peterson, Ramirez, Rappaport, Scholze, and Segal voted in favor of the motion.

Approval of CUPHD Invoice – March 2010

Peterson asked why the invoice was higher than usual. Wallace said the invoice covered the standard core services and the grants. The West Nile Virus Grant was a little higher because CUPHD spent down the grant during March. The full grant amount and no more was spent. The funding was spent on getting supplies ready. Peterson asked if there would be staff costs involved later in the year when the mosquitoes come out. Wallace confirmed staff time would be involved in doing surveillance. She explained the previous grant ended March 31st and a new grant began on April 1st. James asked if some unused West Nile Virus Grant money was returned to the state last year and Wallace confirmed that was correct.

MOTION by Peterson to approve payment of the CUPHD March 2010 invoice; seconded by James. **Motion carried with unanimous support.**

Illinois Public Health Association Consultant Update

Rappaport shared information from a recent conversation with Bob Keller. Keller will have a consultation report ready for discussion at the May meeting. He will send the report to BOH members via email by end of this week. This will afford members the opportunity to read the report in advance. He asked that any questions or comments be shared with Keller in the interim. Keller will prepare a PowerPoint presentation for the May meeting.

James asked if there would be any additional costs with the May 25th meeting because Keller's contract ends on May 1st. Rappaport stated there will be no further costs based on what has already been allocated, according to Keller.

Other Business

Crisis Nursery Beyond Blue Program Third Quarter Report

MOTION by Peterson to receive and place on file the Crisis Nursery Beyond Blue Program Third Quarter Report; seconded by Ramirez.

Jennifer Sampson, who works on the rural Beyond Blue Program, announced the program was close to reaching its goal numbers in the third quarter. Crisis Nursery has been doing many outreach efforts through pediatricians and OB-GYNs. A support group is held every Monday night. Sampson started a new group parent/child interaction group for mothers and infants. The Rantoul activity is going well with space at Parent Wonders. Sampson noted Parent Wonders is losing its funding next year so another space will have to be found. She stated there are numerous pregnant and parenting teens in Rantoul who are in need of services for depression. The nursery has held a playgroup in Tolono all year long as an outreach effort to mothers in southern Champaign County.

Peterson remarked Beyond Blue is obviously a good program, but he wondered how the BOH would continue its funding in future years. James suggested donations. Peterson said the BOH will have to discuss it at some point. Rappaport thanked Sampson for her report.

Motion carried with unanimous support.

Under other business, Rappaport announced the BOH will elect its officers in May. He will complete his fifth year on BOH at the end of his term of June 30th and does not intend to apply for reappointment. He wanted to let the Board know so they could think about who wants to run for President. Peterson asked if Rappaport could be convinced to continue. Rappaport stated he had personal reasons for not applying for reappointment and did not want it to be a surprise.

Closed Session Minutes

Rappaport asked if all BOH members had read the closed session minutes distributed before the meeting. Peterson asked if closed session minutes could be discussed and amended in an open session. Busey clarified the BOH could enter into a closed session without it being on the agenda if anyone wanted to discuss amending the minutes.

MOTION Peterson to approve the March 30, 2010 7:27 p.m. and March 30, 2010 8:32 p.m. closed session minutes without amendment; seconded by Scholze.

James wanted to address each set of minutes separately. **Peterson and Scholze agreed to separate the minutes as a friendly amendment.**

Motion carried with unanimous support to approve the closed session minutes of March 30, 2010 7:27 p.m.

MOTION by James to enter into closed session pursuant to 5 ILCS 120/2(c)21 to discuss minutes of a meeting lawfully closed under the Illinois Open Meetings Act. He further moved the following individuals remain present: the Recording Secretary and the County Administrator. The motion was seconded by Peterson. Motion carried with a vote of 8 to 0. Anderson, Huls, James, Peterson, Ramirez, Rappaport, Scholze, and Segal voted in favor of the motion. The Board of Health entered into closed session at 7:17 p.m. and resumed open session at 7:32 p.m.

Motion carried to approve the closed session minutes of March 30, 2010 8:32 p.m.

Public Participation on Non-Agenda Items Only

There was no public participation on non-agenda items.

Adjournment

The meeting was adjourned at 7:37 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.

smile healthy

Champaign County Board of Health
Monthly Report for April 2010, FY10

Total Number of Patients Seen From All Programs this month: **303**
Total Number of Unique Patients In BOH Fiscal Year 2010: **1015**
Total Number of Participating Providers this month: **10**

Breakdown of current month patients for all programs by town.

Champaign – **79**
Fisher - **3**
Homer – **3**
Ludlow - **1**
Mahomet – **18**
Rantoul – **75**
Sadorus - **1**
Savoy – **7**
Sidney - **3**
St. Joseph - **2**
Thomasboro - **1**
Tolono - **11**
Urbana – **16**
Other - **83**

Mobile Clinic Events

April 2, 2010 » 8:30am - 4pm » Anabel Huling, Rantoul
April 7, 2010 » 9am - 4pm » Lincoln's Challenge Academy
April 12, 2010 » 8:30am - 4pm » Savoy Head Start Restorative and Recall Clinic
April 14, 2010 » 9am - 4pm » Lincoln's Challenge Academy
April 15, 2010 » 9am - 5pm » Frances Nelson Health Center
April 12, 2010 » 8:30am - 4pm » Savoy Head Start Hygiene Only
April 27, 2010 » 8:30am - 4pm » Champaign Head Start Hygiene Only
April 30, 2010 » 9am - 4pm » Prairieview Ogden Elementary
April 30, 2010 » 9am - 5pm » Frances Nelson Health Center

Education and Outreach

4/01/10 Head Start Preschool, Savoy - A staff hygienist provided an educational program and dental educational material to **54 children.**

4/05/10 Barkstall Elementary School, Champaign - A staff hygienist, U of I Extension member and pre-dental student (volunteer) provided an educational program, educational material, and dental supplies to **42 children and 8 adults.**

SmileHealthy – formerly Central Illinois Dental Education and Services (CIDES)
Head Start Dental Clinic . Mobile Dental Clinics . Child Dental Access Program . Dental Health Education
PO Box 154, Champaign, IL 61824-0154 – phone 217.359.7404 – fax: 217.352-9745
www.**smilehealthy**.org

4/06/10 Head Start Preschool, Savoy - A staff hygienist provided an educational program and dental educational material to **54 children.**

4/08/10 Head Start Preschool, Rantoul - A staff hygienist provided an educational program and dental educational material to **72 children.**

4/13/10 Head Start Preschool, Savoy - A staff hygienist provided an educational program and dental educational material to **54 children.**

4/15/10 Head Start Preschool, Urbana - A staff hygienist provided an educational program and dental educational material to **54 children.**

4/17/10 Lincoln Square Mall, Urbana – A staff hygienist and U of I pre-dental students (volunteers) offered a table presentation at Ready, Set, Grow event. Toothbrushes and educational material were provided for **over 75 children and their families.**

4/17/10 YMCA, Champaign – A staff hygienist and U of I pre-dental students (volunteers) offered a table presentation at Healthy Kids event. Toothbrushes and educational material were provided for **over 75 children and their families.**

4/20/10 Head Start Preschool, Rantoul - A staff hygienist provided an educational program and dental educational material to **18 children.**

4/21/10 B. T. Washington Elementary School, Champaign - A staff hygienist together with a U of I Extension member provided an educational program, educational material, and dental supplies to **6 children and 7 adults.**

4/22/10 Head Start Preschool, Champaign - A staff hygienist provided an educational program and dental educational material to **34 children.**

4/23/10 Illini Union, Urbana - A staff hygienist and U of I pre-dental students (volunteers) offered a table presentation at McKinley Health Fair. Toothbrushes and educational material were provided for **400 adults.**

4/27/10 Head Start Preschool, Champaign - A staff hygienist provided an educational program and dental educational material to **26 children.**

4/27/10 Steer Place, Urbana - A staff hygienist together with a U of I Extension member provided an educational program and dental educational material to **10 senior citizens.**

SmileHealthy

Champaign County Board of Health

Fiscal Year 2010 Report

	Dec 09	Jan 10	Feb 10*	March 10	April 10	May 10	June 10	July 10	Aug 10	Sep 10	Oct 10	Nov 10	Total
Bondville													0
Broadlands			1										
Champaign	38	48	125	48	79								338
Fisher	4			1	3								8
Foosland	1												1
Gifford	2	1											3
Homer	1	1	14	2	3								21
Ivesdale		1											1
Ludlow	1				1								2
Mahomet	1	12	2	5	18								38
Ogden	2	1											3
Penfield			2										2
Pesotum	2	2											4
Philo	3												3
Rantoul	53	18	57	37	75								240
Royal	1												1
Sadorus	2			1	1								4
Savoy	3	3	10	5	7								28
Seymour	1	1	1	2									5
Sidney	3	1	2	2	3								11
St. Joseph	3		7		2								12
Thomasboro	42				1								43
Tolono	5	4	12	10	11								42
Urbana	18	18	29	19	16								100
Other	1		38	102	83								224
Total	187	111	300	234	303	0	0	0	0	0	0	0	
Total Unique Patients in FY	187	277	557	760	1015								
Education Contacts	6	249	1051	876	989								3171

Champaign and Urbana children seen either live outside city limits and are county residents or are part of the Head Start program and paid for by Medicaid or other funding.

*Feb will include patients from Give Kids A Smile with C-UPHD IDDS.

Invoice Number:	1005
Date of Invoice:	May 18, 2010
Billing Period:	April-10

To:

Champaign County Public Health Department
1776 East Washington Street
Urbana, Illinois 61802

For the Following Expenses:

533.07 Professional Services - Infectious Disease Prevention & Mgmt	$	9,471.25
533.07 Professional Services - Vital Statistics	$	235.58
533.07 Professional Services - Environmental Health	$	25,821.83
533.07 Professional Services - Administration	$	12,318.59
533.07 Professional Services - PHEP Grant	$	8,344.91
533.07 Professional Services - TFC Grant	$	5,667.58
533.07 Professional Services - West Nile Virus Grant	$	197.88
533.07 Professional Services - Non-Community Water - CU Surveys	$	-
533.07 Professional Services - PHER Phase 1 & 2 Grant	$	5,112.32
533.07 Professional Services - PHER Phase 3 Grant	$	345.00
533.07 Professional Services - County Well Water Testing	$	79.93
Total Amount Due to CUPHD per Contract	**$**	**67,594.87**

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

Champaign County Board of Health
Consulting Report

Reformation for the Future

Robert J. Keller, MBA, CPHA

Table of Contents

I. Introduction

The consultant was commissioned by the Champaign County Board of Health to assess current operating procedures and recommend options available to fulfill its responsibilities to oversee public health services to residents outside of Champaign Urbana. The consultant's services were further procured to recommend approaches that would assist in striking an appropriate inter-organizational balance for the Board of Health's contractual relationship with the Champaign Urbana Public Health District (CUPHD).

The project is divided into three phases: Phase one entails an overview of accepted theoretical frameworks for local health department responsibilities as well as a review of required programs under Illinois statutes and administrative rules. The second phase involves an analysis of four organizational approaches for delivery of public health services to the residents of rural Champaign County and provides an assessment of areas where the current contractual relationship between the Champaign County Board of Health and the Champaign Urbana Health District Board may be improved. The final phase engages a series of recommendations and suggestions for concrete action steps.

The methodology chosen for developing this report includes a review of generally accepted governing board responsibilities, research of Illinois Compiled Statutes, Illinois Administrative Code, Champaign County documents, Champaign Urbana Public Health District documents, interviews with Champaign County Board of Health members, interviews and data gathering from public health administrators in several Central Illinois counties, the 2005 Public Health Institute consultant report and presentation of key facets from literature outlining generally accepted theoretical frameworks for local health department responsibilities.

II. Board Responsibilities

Prior to launching into a more detailed analysis of local health department structure, it is appropriate to review accepted definitions for roles of boards of directors. The Champaign County Board of Health operates as the policy board overseeing operations of the Champaign County Health Department. Even though the current service delivery mechanism utilizes outsourcing through a contract with the Champaign Urbana Health District (CUPHD), nevertheless, the role of the board is unchanged.

There are a variety of definitions found within management literature that attempts to differentiate the policy role of boards of directors and policy execution roles of executive staff. Although these definitions vary somewhat, there are common threads found within all. These include:

- The responsibility of boards to determine organizational policy with the advice of management staff;
- The responsibility of boards to hire and evaluate the organization's chief executive officer;
- The responsibility of boards to assure accountability to the public
- The responsibility of boards to evaluate the effectiveness and soundness of the organization

Boards of directors in the not-for-profit, governmental and private sectors are customarily part-time and members are appointed or elected not for their specific subject-matter expertise but, instead, for their general oversight competencies. Therefore, day-to-day operation and the responsibility to deliver outcomes is appropriately vested in an organization's chief executive officer and staff. The relationship the board cultivates with its CEO is of the utmost importance.

Common functions of a governing board are to:

- Periodically review the organization's legal responsibilities and framework;
- Assure compliance with requirements of government and private oversight entities and contractors for service;
- Make annual disclosure to the public on the organization's services and financial condition;
- Assure compliance with generally accepted accounting standards; and,
- Assure revenue and expenditures are in line with the approved budget.

As stated, the governing board of an organization has sole responsibility for policy determination and delegates the responsibility to execute policy to the organization's chief executive officer. The governing board has the responsibility to oversee the development of long-range plans. [i]

In addition to generally accepted roles and responsibilities for governing boards, there are specific statutory responsibilities for a county board of health. 55 ILCS 5/Div. 5-25 County and Multi-county Health Departments denotes these responsibilities:

> It shall:
> 1. Hold a meeting prior to the end of each operating fiscal year, at which meeting officers shall be elected for the ensuing operating fiscal year;
> 2. Hold meetings at least quarterly;
> 3. Hold special meetings upon a written request signed by two members and filed with the Secretary or on request of the medical health officer or public health administrator;
> 4. **Provide, equip and maintain suitable offices,** facilities and appliances for the health department;
> 5. Publish annually, within 90 days after the end of the county's operating fiscal year, in pamphlet form, for free distribution, an **annual report** showing the condition of its trust on the last day of the most recently completed operating fiscal year, the sums of money received from all sources, giving the name of any donor, how all moneys have been expended and for what purpose, and such other statistics and information in regard to the work of the health department as it may deem of general interest;
> 6. Within its jurisdiction, and professional and technical competence, **enforce and observe all State laws pertaining to the preservation of health,** and all county and municipal ordinances except as otherwise provided in this Division;
> 7. Within its jurisdiction, and professional and technical competence, **investigate the existence of any contagious or infectious disease** and adopt measures, not inconsistent with the regulations of the State Department of Public Health, to **arrest the progress of the same;**
> 8. Within its jurisdiction, and professional and technical competence, **make all necessary sanitary and health investigations and**

inspections;

9. Upon request, give professional advice and information to all city, village, incorporated town and school authorities, within its jurisdiction, in all matters pertaining to sanitation and public health;

10**. Appoint a medical health officer** as the executive officer for the department, who shall be a citizen of the United States and shall possess such qualifications as may be prescribed by the State Department of Public Health; **or appoint a public health administrator who shall possess such qualifications as may be prescribed by the State Department of Public Health** as the executive officer for the department, provided that the board of health shall make available medical supervision which is considered adequate by the Director of Public Health;

10 1/2**. Appoint such professional employees** as may be **approved by the executive officer** who meet the qualification requirements of the State Department of Public Health for their respective positions provided, that in those health departments temporarily without a medical health officer or public health administrator approval by the State Department of Public Health shall suffice;

11. Appoint such other officers and employees as may be necessary;

12. **Prescribe the powers and duties of all officers** and employees, **fix their compensation**, and authorize payment of the same and all other department expenses from the County Health Fund of the county or counties concerned;

13. **Submit an annual budget t**o the county board or boards;

14. **Submit an annual report** to the county board or boards, explaining all of its activities and expenditures;

15. Establish and **carry out programs and services in mental health**, including mental retardation and alcoholism and substance abuse, not inconsistent with the regulations of the Department of Human Services;

16. Consult with all other private and public health agencies in the county in the **development of local plans** for the most efficient delivery of health services.

In addition, Illinois Compiled Statute define optional duties boards of health may provide:

1. Initiate and carry out programs and activities of all kinds, not inconsistent with law, that may be deemed necessary or desirable in the promotion and protection of health and in the control of disease including tuberculosis;

2. Receive contributions of real and personal property;

3. **Recommend to the county board or boards the adoption of such ordinances** and of such rules and regulations as may be deemed necessary or desirable for the promotion and protection of health and control of disease;

4. **Appoint a medical and dental advisory committee** and a non-medical advisory committee to the health department;

5. **Enter into contracts** with the State, municipalities, other political subdivisions and non-official agencies for the purchase, sale or exchange of health services;

6. **Set fees** it deems reasonable and necessary (i) to provide services or perform regulatory activities, (ii) when required by State or federal grant award conditions, (iii) to support activities delegated to the board of health by the Illinois Department of Public Health, or (iv) when required by an

agreement between the board of health and other private or governmental organizations, unless the fee has been established as a part of a regulatory ordinance adopted by the county board, in which case the board of health shall make recommendations to the county board concerning those fees. Revenue generated under this Section shall be deposited into the County Health Fund or to the account of the multiple-county health department.

7. Enter into multiple year employment contracts with the medical health officer or public health administrator as may be necessary for the recruitment and retention of personnel and the proper functioning of the health department.

(C) The board of health of a multiple-county health department may hire attorneys to represent and advise the department concerning matters that are not within the exclusive jurisdiction of the State's Attorney of one of the counties that created the department.

(Source: P.A. 89-272, eff. 8-10-95; 89-507, eff. 7-1-97.) [ii]

Many of the statutory responsibilities of county boards of health pertain to organizational powers. From a program standpoint it is clear from express statutory language that once formed county boards of health **must be capable of investigating and responding to incidence of infectious diseases.** A clear role in health planning and consultation with other governmental jurisdictions is express within the Act. One area that has been subject to interpretation is the stated duty of a county board of health to establish programs in mental health, developmental disabilities and substance abuse. The role of local health departments within these areas range from nothing more than informal relationships with providers of behavioral health services to sophisticated service delivery and local mental health authority responsibilities. [iii]

III. Public Health Framework

Another key element in understanding the function of public health is to comprehend its theoretical framework. One taxonomy developed by the Institute on Medicine (IOM) helps to better understand the responsibilities of local public health agencies. This overview appeared in its 1988 publication *The Future of Public Health*. The IOM identified three core functions: Assessment, Policy Development and Assurance. Later, the U.S. Centers for Disease Control promulgated the National Public Health Performance Standards and incorporated the Ten Essential Services for community public health systems. Understanding the distinction between a community public health system and a community health agency is important to this review. The "public health system" describes the various community stakeholders while a "community health agency" generally refers to a local health department. The depiction below lists the Ten Essential Services within the context of the core functions.

The Three Core Public Health Functions
And the Essential Public Health Services

Assessment

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services

Policy Development

- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety.
- Research for new insights and innovative solutions to health problems

Assurance

- ☐ Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- ☐ Assure a competent public health and personal health care workforce
- ☐ Inform, educate, and empower people about health issues
- ☐ Mobilize community partnerships to identify and solve health problems [iv]

As stated previously, the overlay portrayed above associates the core functions of public health with what is commonly referred to as the Ten Essential Services. The importance of this for the Champaign County Board of Health (CCBOH) is to utilize the typology to periodically evaluate the presence of public health services within the community and, further, to assess to what degree the Board of Health is fulfilling its role in serving the public. It must be understood that the responsibility of a local health department is not to provide the breadth of public health services and functions within a given jurisdiction, but rather to assure them. Local health departments often serve as brokers and enablers of public health services through other providers within their respective areas.

IV. Mandated Services

A critical situation facing the Champaign County Board of Health relates to its future financial condition. For the 2010 budget year, the CCBOH was presented with a contract proposal by the Champaign Urbana Public Health District that included a 41% increase in program costs. As a result, the Board of Health was required to expend funds within its unencumbered fund balance to cover the deficit. This dip into reserves cannot be sustained for budget year 2011. The Board of Health is further restricted due the presence of the Illinois Property Tax Extension Limitation Law (PTELL) restrictions on its ability to generate additional tax revenue. Thus, the upcoming budget will need to contain a thorough analysis of what services are required under law or administrative rules.

The first place to turn in defining statutory responsibilities is the Illinois Administrative Code, informally referred to as rules. Essentially, rules are written to provide detail to program requirements where statutes are vague. There are two rules that help answer the question of what services are mandated. The Joint Commission on Administrative Rules (JCAR) defines the conditions that must be present for a local health department to be certified. Certification opens the door for delegation of Illinois Department of Public Health (IDPH) responsibilities and eligibility for funding under the Local Health Protection Grant (LHPG) as well as other categorical grants distributed by IDPH.

Certification rules, included as Attachment A., require the following:

- The presence of a public health administrator that meets minimum qualifications for the position
- The presence of a medical officer to consult with the public health administrator
- Documentation of the ability to investigate and monitor infectious disease incidence
- Documentation of the ability to conduct community public health educational endeavors
- Documentation of the conduct of an internal organizational capacity assessment
- Documentation of a community public health needs assessment (IPLAN)
- Documentation of the completion of a community health plan
- Demonstration of the capacity to engage in public health advocacy and engage coalitions
- Demonstration of the ability to meet annually with allied community organizations
- Dissemination of public health reports
- Implementation of programs addressing IPLAN priorities[v]

Cross referencing the rules with the local health department act contained within the Counties Code reveals that the rules are loosely tied to several mandatory service components along with the IPLAN requirement that first appeared in rule during the '90s.

V. Local Health Protection Grant Services

Each certified local health department, by definition, is eligible for the Illinois Department of Public Health Local Health Protection Grant, provided that the four listed health protection services are provided in accordance with standards defined within the LHPG rules. Funds are allocated to local jurisdiction based upon a formula. The current formula is tied to the historical amount awarded to each jurisdiction with a $50,000 minimum. Any additional funding received through the Illinois General Assembly for the LHPG would be subject to distribution using 50% of the funds by a population driver and 50% being distributed utilizing a 200% of poverty index. The LHPG figure listed for the Champaign County Health Department for FY10 is $125,403.[vi]

LHPG rules allow local health departments to devote grant revenues to support any public health program. However, in order to be eligible to receive the full amount of funds, local health departments must carry out programs in **infectious diseases, food protection, potable water supply and private sewage disposal**. The four LHPG programs must be conducted in accordance with the provisions of Title 77: Public Health Chapter I: Department of Public Health Subchapter h: Local Health Departments Part 615 Local Health Protection Grant Rules.

In essence, in addition to the requirements listed within the mandated services area of the certification rules and described in the previous section of this report, the Champaign County Board of Health is required to deliver the four services alluded to in order to remain eligible for full funding under the LHPG. Therefore, it is critical that within the funding constraints available for the Board of Health that these four services receive the highest priority for allocation of the Local Health Protection Grant.

Attachment B., Local Health Protection Grant Rules, to this report enumerates the requirements for meeting the minimum levels of service for the four program areas. It is important to note that more detailed requirements for how these programs are found in corresponding Illinois statutes and administrative codes governing communicable disease control, tuberculosis control, food protection services, potable water standards and private sewage disposal services.

The required core components of each of the LHPG programs are listed below:

Infectious Disease:

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.

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:

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:

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:

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.

Potable Water Supply

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

1) T **he 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 reinspection 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 under 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.

Private Sewage Disposal

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, 1988, **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 agreement.

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.

Reporting and General Requirements

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.

Emergency Preparedness and 24 Hour Contact

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.

VI. Program Summary

In summary, the Champaign County Board of Health is responsible for assuring it meets IDPH certification standards which includes assurance it has an **administrator meeting statutory requirements,** it is advised by **a medical officer meeting statutory requirements**, it **investigates infectious diseases** and has in place **a community health assessment and community health plan (IPLAN)**. [vii]In addition, in order to receive its full allocation of the Local Health Protection Grant, the Champaign County Board of Health must deliver **programs in infectious disease, food protection, private sewage disposal and potable water** and have in place **emergency response capacity** in accordance with the IDPH rules.[viii]

VII. Current Approach to Service Delivery

Since its inception, the Champaign County Board of Health has chosen to meet its statutory obligations through contract with the Champaign Urbana Health District. The Board of Health is currently in its 3rd year of a six year contract that expires on November 30, 2013. The prime value of contracting with an existing certified local health department for the delivery of services are the economies of scale created through a single administrative entity and reliance on the program expertise of an established department. Policy oversight barriers exist for the Board of Health in overseeing services delivered under the aegis of a separate governmental body. The relationship between the Champaign County Board of Health and the Champaign Urbana Health District has largely been one of a contractor - contractee association. Traditionally, this type of relationship involves a set product or service being delivered by the contractee to the contractor within specifications. However, as has been shown through statute and rule, local boards of health are charged with the responsibility for determining priorities and assuring that the public health needs of its constituents are being met.

Herein lies the conflict: CUPHD is organized to deliver services to the residents of a largely urban jurisdiction and has adapted to its role as a contractee of the Champaign County Board of Health, yet its prime governmental responsibility is to its three member board and the townships being served by CUPHD. It is clear that the current contract severely restricts the Champaign County Board of Health in its policy oversight role. Efforts to extend the boundaries of these constraints have been largely *ad hoc* in nature and have resulted in sporadic inter-organizational conflict. As will be discussed later, the merits of an outsourcing model are myriad. However, contractual arrangements can be subject to irreconcilable disputes. Therefore, the question is posed as to what alternatives are available to the Champaign County Board of Health after the current contract expires in 2013.

VIII. Alternative Approaches to Service Delivery

This section will be devoted to an analysis of alternative approaches to delivering public health services to the residents of Champaign County following the expiration of the current contract in 2013.

Countywide Health Department

An seemingly simple solution to the fragmented approach now in place to deliver public health services in Champaign County is to consolidate all public health authority responsibilities under a countywide local health department. The advantages include: consolidated governance, consolidated planning, consolidated policy development and a unified and consistent presence for public health within the county.

The systems design with two separate health departments within the same county is atypical for downstate Illinois. Cook County is served by both the City of Chicago Public Health Department and the Cook County Health Department as well as several smaller health districts and municipal health departments. The demographics and political environment within Cook County make that condition virtually incomparable with the remainder of the state. St. Clair County, near St. Louis, is the only downstate county jurisdiction covered simultaneously by a health district and a county health department. Much as the case with Champaign County, the East St. Louis Health District's formation antedated the establishment of the St. Clair County Health Department. Much of the focus of the district at its inception was the provision of clinical services for its substantial medically indigent population. St. Clair County's population is 260,227 according to the 2006 population estimate. [ix] The estimated population of East St. Louis was 30,573 in 2003. [x] Separate local health departments are still maintained for both the district and the remainder of the county. The political environment is such that no impetus has been started to combine the two fully staffed departments.

Prior to 1993, the Springfield City Public Health Department co-existed with the Sangamon Health Department that was established in 1988. There were no discussions prior to that date to merge the two operations. Much as the case is with delineation of authority in Champaign County, the city health department limited its public health programs to the corporate limits of the city of Springfield while the Sangamon County Health Department assumed responsibility for the remainder of the county. Virtually all environmental programs, such as private sewage disposal and potable water, were handled by the county health department. Local ordinances and program delivery modalities between the two departments differed substantially. Discussions concerning the city divesting itself of public health responsibilities and transferring those services to the county health department began in earnest during the early '90s. Much of the impetus for those discussions centered on potential economies of scale and budgetary savings for the city. Collective bargaining issues and a political divide among the council members put the effort on hold for several years. Talks were again resumed in 2003 and culminated in 2006 with the formal transfer of authority by action of the city council. [xi]

Political considerations aside, Champaign County would need to rely on the Public Health District Act. P.A. 86-1324. for guidance in beginning a similar process. The provision of the Public Health District Act that covers the Champaign Urbana Public Health District is as follows:

> Where a public health district consists of 2 or more adjacent towns, the supervisors of the towns, together with the chairman of the county board shall be members of the board of health for the public health district; provided, that where the public health district consists of 2 towns, and the supervisor of one of such towns is the chairman of the county board, the presiding officer of the county board, with the advice and consent of the county board, shall appoint a qualified voter from one of such towns to serve as a member of the board of health for a term of one year. [xii]

In order for the Champaign Urbana Public Health District to formally cede its authority to the Champaign County Board of Health for the purpose of establishing a single local public health authority for the county, a formal action by the district to place a referendum on the ballot to dissolve the Champaign Urbana Health District would need to be pursued. The statutory reference follows:

> Sec. 5-25009. Abandonment of city, village or town department. Any city, village or incorporated town, or combination thereof or any public health district which maintains its own independent health department may abandon the same and become integrated in the county or multiple-county health department. The method of abandonment, unless otherwise prescribed by law, shall be the same as the method of adoption. Abandonment shall become effective at the end of the fiscal year of the city, village, incorporated town or public health district. [xiii]

Since the District Act is silent on specific procedures for abandonment, it appears a literal reading of Chapter 55, ILCS would require a referendum similar to the one that established the Champaign Urbana Health District for the purpose of initiating a dissolution and transfer of services.

The advantages of creating a countywide local health department are clear: Champaign County would join the mainstream of counties in the design of its provision of public health services; there would be no jurisdictional confusion on the part of the public concerning local public health authority; planning and public health strategy would be comprehensive; administrative and policy barriers as well as potential conflict as a result of its existence would be eliminated; and, there would be no need to blend two existing health departments as was the case in Sangamon County.

There are, however, a downsides to creating a countywide local public health department. Champaign County could lose an estimated $100,000 in formula funding through Illinois Department of Public Health Grants. The Local Health Protection Grant, for example, is allocated to local health departments using a formula that provides minimum awards to each eligible department. Champaign County operates with two local health departments - the Champaign Urbana Public Health Department and the Champaign County Health Department - and as a result, receives two minimum awards upon which to build the base for the remainder of the award. The same philosophy is applied to the IDPH Tobacco Free Communities Grant, emergency preparation funding and West Nile virus contracts. The minimum awards are not mandated under statute or regulation but the practice of distributing funds in this manner has been a longstanding practice of the Illinois Department of Public Health. Loss of funds could be ameliorated through negotiation. At the time of the merger in Springfield, the Illinois Department of Public Health instituted a hold harmless provision regarding state resources.

A second potential negative repercussion of establishing a countywide department would be the political capital and energy invested in bringing it to fruition. As alluded to previously, a considerable expenditure of time and effort, as well as rancor, occurred in Sangamon County before that countywide department was established. However, it must be noted that relations between the city of Springfield and Sangamon County did progress when improvements in services were noted. An intergovernmental consensus would need to be established before a referendum to abolish the district could be placed before the voters.

A third hurdle to overcome is the vastly different tax rates for the two bodies. If Champaign County was not under PTELL, the practical ability to blend the rates across the county would be present. Raising taxes absent PTELL would only entail overcoming political obstacles within the governing bodies. However, the existence of PTELL requires that a referendum be passed by the voters to establish a uniform rate throughout the county. Given the contemporary political climate, at least in the short-term, this would be a daunting task.

On balance, short-term practical constraints set aside, it is this consultant's opinion that the long-term advantages associated with a countywide public health department outweigh the deficits. In order to move forward on such an effort an independent body such as the League of Women Voters, or a separate community task force, would need to take this up as a cause for the betterment of county residents.

Multiple-County Health Department

55 ILCS 5/5-2500, Sec. 5-25001 allows for the establishment of multiple-county health departments. The referenced section of the Act reads as follows:

> Any county or two or more adjacent counties may, by resolution of the county board or county boards of the respective counties, as the case may be, or upon approval by referendum as hereinafter provided, establish and maintain a full-time health department; provided, that four or more counties must obtain the approval of the State Department of Public Health prior to establishing a multiple-county health department. The approval may be obtained upon application by the county board of any county, containing such information as may be required by the State Department. Approval shall be granted if the State

Department determines that the establishment of the multiple-county health department is essential to the health requirements of the area affected.

The remainder of the steps needed to organize a multiple-county health department is contained within the above reference statute appended as Attachment C. The advantage of establishing a multiple-county health department involve the economies of scale operating under a single administration and staff. The deficits include a board of health that represents more than one county government and the large geographical area covered. It is not uncommon for county boards to have some influence on the enforcement philosophies exercised by their respective health departments. Enforcement ordinances would need to be compatible to assure consistency for staff working across county lines. Neighboring departments such as the DeWitt-Piatt Bi-County Health Department or the Vermilion County Health Department would need to be approached in order to begin a dialogue. As is the case with establishing a countywide health department, concurrence on tax rates and proportionate share of costs would be an inevitable part of the negotiations between the respective governing bodies.

Much the same as with a countywide health department, the economies of scale and administrative efficiencies are advantages associated with a multiple-county health department. However, this condition is somewhat mitigated by the expanded geographic area covered by a rural local health department. As has been pointed out, the political complexities associated with multiple-county health departments present unique challenges. The multiple-county model is present in a number of downstate areas. One multiple-county health department in southern Illinois covers seven counties and has maintained relative effectiveness but has struggled financially.

The staffing model used in a multiple-county health department would parallel that of the countywide health department discussed previously. If rural Champaign County were to be merged into a larger multiple-county health department, it is likely that a satellite office in the county would need to be established and a local staffing complement would be added. It is likely that local staff would be comprised of direct service staff with a central office staff engaging in support work. It is probable that costs would not be dissimilar to those experienced currently under the CUPHD contract. There may be some savings in overhead due to compensation levels of smaller health departments not being commensurate with larger departments. This is born out when researching compensation studies conducted through the Illinois Department of Public Health that survey local health departments.

Standalone Local Health Department Covering Areas Outside CUPHD Jurisdiction

One model that deserves an in-depth review is the creation of a staffed local health department to serve areas outside the jurisdiction served by CUPHD. The advantage of this approach would be to allow the Champaign County Board of Health to have unfettered oversight responsibility for the public health programs for which it is responsible. A potential drawback might be whether or not there is enough critical mass to support a standalone public health authority. It is important to understand that, numerically, most of the local health departments in Illinois serve jurisdictions of under 50,000 residents.

One benefit of this approach, not present within the other options, is the ease with which it could be undertaken from a structural standpoint. There would be no conflict with regard to governance or tax rates, those features would remain as they are. Another advantage would be that the Champaign County Board of Health would have exclusive authority over policy direction. The administrator of the Champaign County Health Department would be under the unilateral direction of the Board of Health. There may be less overhead due to a reduced amount of complexity in the operation and production function. A disadvantage that may offset the simpler model would be reduction in expertise built into the administrative structure. For example, a larger organization may be of such critical mass that an administrative staff member is assigned exclusively to the human resources function or third party

billing. Within a smaller department those duties are generally absorbed by the administrator or other office support staff. Another drawback that may be qualitative in nature, for example, may be the inability to attract a trained and competent staff member to oversee epidemiology functions. A smaller department would not be able to support a dedicated professional to carry this function nor attract staff with the requisite credentials.

A major question is whether or not this option could be cost-effective. In order to gauge the potential, the consultant examined structures in other jurisdictions to determine what type of staffing would be required for a standalone department, what the likely expenses would be and what revenue sources would be available. The analysis is based upon an assumption that the existing menu of services would remain in place. This is a safe assumption, since those services are either covered 100% by IDPH contract revenue or fall under the definition of mandated services and, therefore, covered by a combination of property tax resources or fees. The vital records service was eliminated for this exercise since this is not a mandated program. In many counties, the county clerk serves as the registrar. It would be fairly easy to add the vital records service back into the mix for analysis purposes, however, that would create three separate entities within the county where birth and death certificates could be purchased (county clerk, CUPHD, and a county health department).

Based upon a review of allocation of environmental health services by function and other programs offered through other local health departments, existing staffing patterns through the current contract and the consultant's own experience within these areas, a simulated budget scenario was generated and incorporated as Attachment D.

Personnel:

The following personnel were identified as being necessary to sustain the operation of a smaller local health department covering the rural jurisdictions:

Title	Compensation	FTE
Administrator	$70,000	1.00
Director of Environmental Health (LEHP)	$55,000	1.00
Sanitarian LEHP in Training	$37,000	1.00
Environmental Health Inspector	$30,000	1.00
Communicable Disease Dir/RN	$48,000	1.00
Immunization RN	$42,000	1.00
Env Inspector-Emergency Response	$18,500	0.50
Senior Office Support Specialist	$30,000	1.00
Environmental Health Office Support Specialist	$25,000	1.00
Accounting Clerk	$25,000	1.00
Health Education/Communications/Tobacco Staff	$35,000	1.00
Misc Part-time	$3,500	0.35
STD/TB RN	$21,000	0.50
Infectious Disease Office Support Staff	$25,000	1.00
Receptionist/Office Support	$25,000	1.00

These personnel are allocated to the various program cost centers based upon an assessment of the time needed to carry out those functions. The Tobacco Control, Emergency Preparation Grant and West Nile virus programs are budgeted at levels consistent with the finite resources available today. Administration, infectious disease, food sanitation, temporary food, private sewage disposal, potable

water, abandon well and water well testing programs were budgeted based upon an assumption of need. The compensation envisioned is somewhat lower for management staff than levels found at the CUPHD. However, it is important to note that expected salary levels are commensurate with smaller jurisdictions and the comparable levels of responsibility. The cost structure presented here serves only as a proxy for what could actually be developed based upon specific qualifications of staff and potential resource sharing at the county level.

Program Costs:

Another facet of this analysis is to examine program cost comparability between the proposed budget and information provided through CUPHD[xiv] A comparison for administration, infectious disease, food protection, potable water, and private sewage disposal follows:

	CUPHD	Proposed Health Department
Administration	$147,828	$190,167
Infectious Disease	646,900[xv]	249,949
Food Protection	120,167	127,843
Private Sewage Disposal	41,105	78,985
Potable Water Program	22,824	38,348

The administration cost center for the proposed health department is significantly higher than costs under the current contract. The proposed health department would need to recruit and retain an experienced administrator meeting IDPH certification standards. Depending on that staff member's background and credentials, he or she might be able to simultaneously oversee selected program areas while administering a smaller department. This has been the case in some rural departments. CUPHD's cost centers contains much smaller increments of multiple of staff to arrive at the $147,828 figure. One advantage of the contract model is to utilize smaller FTE increments of specialized staff. A standalone health department must rely on fewer, less specialized, fulltime staff to carry out administrative functions.

It is difficult to compare the $646,900 CUPHD infectious disease cost center displayed within its FY10 budget with the one developed for the proposed health department. CUPHD used an approach that steps down application of revenue and ends with a net cost to the county contract of $113,655.

The sum of the three environmental health programs (food, potable water and private sewage) derived through the CUPHD managerial accounting system for the period July 1, 2008 through June 30, 2009 equals $245,176 compared with a greater amount shown in its FY10 budget submission. This may be explained by changes in CUPHD's managerial accounting assignment of costs for the current budget year. It must be remembered that the data used for the CUPHD column in this report is derived from their 2008/2009 cost report. The FY10 CUPHD budget information showed costs for the three programs to be $309,862. This budget figure does not break environmental health costs down by program. Comparable costs for all environmental health programs in the proposed health department budget is $266,587.

The budget that was developed for the proposed standalone health department utilized revenue projections approximately in line with current budget figures. There would likely be a need to adjust fees upward in order to keep pace with incrementally rising costs. Another factor worthy to consider is that the proposed standalone health department assumes that the new department would need to cover the cost of space for its operation. Approximately $47,000 is set aside for this purpose. If

Champaign County could provide the needed space through its existing facilities, the cost structure would be significantly reduced.

Merging Administrative Functions of County Departments:

Another factor that could achieve economies of scale under the standalone approach would be to combine management of the public health department with another county department. In Coles County, the public health administrator also serves as the director of the Community Mental Health Board.[xvi] In McLean County, the County Health Department provides administrative oversight to programs under the auspices of the McLean County Tuberculosis Care and Treatment Board and the McLean County Board for Care and Treatment of Persons with a Developmental Disability. The McLean County model sets up concurrent appointments of members serving on the public health, tuberculosis care and treatment and developmental disabilities persons boards. The bylaws and functions of those boards, along with their meeting structures, remain separate but their missions are complimentary. To further illustrate this type of consolidation, in the Town of Normal the town council serves as the liquor control commission and in the city of Bloomington their council serves as members of the City of Bloomington Township Board of Supervisors. Champaign County does have a Community Mental Health Board and Board for Care and Treatment of Persons with a Developmental Disability. The design of what is commonly referred to as 708 boards is strikingly similar to that of county boards of health. If a standalone option is explored, the compatibility of merging administrative functions of both boards should be considered.

In addition to financial advantages, program enhancement and combinations could take place as well. 708 boards engage in community planning similar in scope to IPLAN. Public health plays a lead role in maternal and child health programs while 708 boards engage in early intervention services for developmentally delayed infants and toddlers. 708 boards are involved in substance abuse prevention and treatment while public health departments engage in tobacco prevention and control programs. Chronic disease management plays an ever-increasing role in meeting the community support needs of chronically mentally ill. This is not an exhaustive list but serves to illustrate the programmatic coordination potential. The merging of public health and community behavioral health programs is present in larger counties such as DuPage, Lake, Will and in downstate McLean counties.

Summary:

It is the consultant's opinion that Champaign County could support a standalone local health department within available resources. As depicted here, such a health department would provide only mandated and LHPG services with a potential decline in quality due to size and resource constraints. For example, under the current CUPHD contract the county has access to 15% of an epidemiologist's time and 10% of an infectious disease director for program expertise. However, it can also be posited that daily need for highly specialized staff capability may not be of great importance within the more rural jurisdiction. An alternative approach might be for the proposed health department to reduce its staff in exchange for contracting with CUPHD for select expertise. The negative impact of the cost limitations may be ameliorated by combining administrative functions with the Champaign County Mental Health Board as discussed above.

CUPHD Contract

An obvious option for the Champaign County Board of Health is to continue its contractual relationship with CUPHD for basic services. The model whereby the CCBOH purchases services from CUPHD was initiated at the inception of the county health department. The model, if executed properly, can emulate many of the advantageous features of a countywide health department. Under this approach there is no need to blend adjusted tax rates. The economies of scale created and the critical mass

generated through a larger local health department, allow for specialized staff skill to be made available for the operation of services within rural areas. A consulting report submitted to the Champaign County Board of Health, conducted in 2005 by Kevin Barrett, Dr. P.H. of the Illinois Public Health Institute, arrived at the same conclusion. Dr. Barnett stated in his consultant's report that continuation of the contract "...represents the best option in terms of preserving economies of scale and reinforcing the public trust and commitment of the parties involved to make optimal use of tax revenues." [xvii] However, Dr. Barnett went on to say on page 9 of that report that the structure of the current contract gives the bulk of decision-making authority to CUPHD. Dr. Barnett's comments follow:[xviii]

> The current CCBOH – CUPHD contract gives the bulk of decision-making and oversight responsibilities to the CUPHD board and staff. As such, it does not provide a basis for the CCBOH to effectively fulfill their responsibilities to the residents of Champaign County outside of the Champaign-Urbana district parameters. The most distinctive reflection of this inequity in governance and oversight responsibility is item #20 of the contract, which indicates that
>
> > "The services to be provided by the Public Health District shall be provided at its existing main facility in Champaign, Illinois, and at such other locations if any in Champaign County within and outside the jurisdictional boundaries of the Public Health District as it shall determine. The Public Health District can provide some or all services at any particular facility as it alone determines. The parties may agree to the provision of selected services at additional locations with the additional expenses being reimbursed by the County ant its Board of Health to the Public Health District."

Clearly, this aspect of the current contractual relationship remains in effect and is a major source of friction between the parties. The consultant conducted structured interviews with Champaign County Board of Health members during late March and early April of 2010. [xix] Following are comments made by members reflecting their views on the current execution of the contract and perspectives on what is needed within a new contract:

> *Clearly establish what services the Board of Health is purchasing, at what cost for each discrete service and within specified quality parameters.*
>
> *Clear and effective legal representation needs to be present that takes the Board of Health's areas of interest and assures that they become priorities within the wording of the contract.*
>
> *Regular Board of Health defined format for quarterly reporting on services and revenue and expenditures for each service.*
>
> *The relationship between the Board of Health and the contracted administrator needs to be more clearly spelled out and policy latitude of the Board of Health to provide oversight to the position.*
>
> *The grace period and criteria for terminating the contract needs to be more balanced, a one year's notice may be too long.*
>
> *The contract should begin to spell out ways in which an integration of policy oversight between the two boards should occur e.g., an executive council comprised of members of both boards to jointly oversee integrated policy and direction of the administrator. Perhaps as a prelude to merging the two boards or integrating into a countywide county health department under Illinois statute.*
>
> *The ability of the Board of Health to set budget constraints*
>
> *An element that spells out a requirement that CUPHD assess the needs of residents outside of the district's jurisdiction and pursue resources to meet those needs (i.e., rural health initiatives)*
>
> *Assure that a formal vote of the CUPHD Board is recorded approving the contact.* [xx]

It is clear from the above responses made by CCBOH members that the current contract is viewed as being biased toward CUPHD. It allows that entity to determine the scope of services and their corresponding cost parameters. An inherent conflict may emanate from differing perspectives of the two parties on the nature of the contract itself. Whereas CUPHD may perceive its role as providing a vehicle for the CCBOH to provide public health services to the residents of rural Champaign County, the board of health appears to view its role differently. Board members were asked to characterize the ideal contractual relationship between the two boards based on one of the following models:

The CUPHD is a contractor delivering a predefined outcomes to the Board of Health with minimal oversight

The CUPHD is a contractor responsible for carrying out the policy charge of the Champaign County Board of Health

The CUPHD serves as the staff of the Champaign County Board of Health under contract and is subject to policy oversight

The CUPHD serves as both the local public health department for the district as well as the jurisdiction outside of Champaign-Urbana and , therefore, serves both boards, from a policy perspective, in an equal capacity [xxi]

The consensus selection was the third option where CUPHD staff is characterized as serving simultaneously as Champaign County Health Department staff subject to Board of Health policy oversight. One member selected the second description while one member selected the fourth portrayal. However, Paragraph 15 (b) of the current contract specifies that all employees under the agreement "...are employees of the Public Health District for all purposes related to this Agreement." The paragraph goes on to point out that "...[t]hey are not employees of the County or the County Health Department for any purpose related to this Agreement." Section 14 of the contract designates the CUPHD administrator as the administrator of the Champaign County Health Department. In keeping with the limitations discussed above, it is stated that "[d]ecisions regarding the Public Health Administrator are solely within the authority of the Board of Health of the Public Health District." Section 14 further states that the CCBOH may complete a "...peer review evaluation of the public health administrator of the public health district..." One could posit that a performance review of a chief executive officer absent the ability to shape the behavior of that individual provides little ability to impact the county health department's policy direction. When asked during the interview phase of this project what role the CCBOH should play in evaluating the public health administrator the following composite response was elicited:

> *This is difficult due to the fact that the BOH has no direct oversight or policy direction of the administrator. The two boards might be able to accomplish this through a joint evaluation process. There should be clearly defined objectives for the administrator and benchmarks for service delivery levels and cost. Data needs to drive the evaluation. It was suggested that the percentage of the population represented by the BOH ought to be the percentage of the annual evaluation score for the incumbent. The quality of the professional relationship between the administrator and the board needs to be evaluated and be part of the evaluation. This year's process was last minute and did not allow time to develop a consensus evaluation.*[xxii]

Paragraph 20 of the contract states that services are to be provided by CUPHD "...at its existing main facility in Champaign, Illinois, and at such other locations as the Public Health District shall determine." [xxiii]. Both these provisions are clearly at odds with the consensus opinion of the CCBOH on how the bilateral nature of the contract should be executed.

Another area cited by a board member was the lack of marketing identity afforded the Champaign County Health Department. It was stated that rural taxpayers are paying for programs, and citizens are receiving services, that are largely characterized as being products of CUPHD. A new contract should address marketing identity of the Champaign County Health Department to include presence in all publications and public information dissemination affecting its coverage area. This would include identity on the website as well as recognition in all media releases.

As can be discerned from these key elements of the contract, absent the ability to determine venues for service delivery and the ability to direct its chief executive officer, the CCBOH has severe limits placed on its policy-making role. This supports the findings of the 2005 report that similarly stated that the existing contract does not allow the CCBOH to effectively carry out its policy authority.

Another impediment to the policy-making autonomy of the CCBOH as spelled out in the contract is the requirement that the Champaign County Board be a signatory to the agreement. Under Chapter 55 of Illinois Compiled Statues, boards of health have express authority to "[e]nter into contracts with State, municipalities, other political subdivisions and non-official agencies for the purchase, sale or exchange of health services." Although for the purposes of inter-department cooperation the CCBOH is free to include the Champaign County Board as a party to the contract, it is not required under state law. At its meeting in November of 2009, the CCBOH voted unanimously to provide the required one year notice to terminate the agreement between the two parties, as specified within contract language, for the purpose of renegotiation. However, the county board chose not to authorize the termination and required the CCBOH to operate under contact provisions it was not fully in accord with. It is this consultant's view that the three party arrangement unnecessarily undermines the CCBOH's role under Illinois statues.

As stated earlier within this report, the existing agreement is not due to terminate until November 30, 2013. Nevertheless, the CCBOH can begin to establish priorities for proposed changes in that agreement when negotiations begin for the next agreement. This can take the form of strategy sessions on the part of the CCBOH to set forth its critical negotiating points. Of more immediate importance is that the CCBOH can begin to restructure how the CCBOH does business with CUPHD within the parameters of the current contract as a transition through redefining program and fiscal reports.

Reporting:

One of the wishes CCBOH members expressed during the interviews was to improve reporting by creating more formality. As part of the information gathering process through interview questions, the following options were presented by the consultant for consideration for future reporting under the existing agreement:

10-15 minute education sessions presented by CUPHD staff at each board meeting on various program components

Quarterly statistical and narrative reports reconciling actual performance to predetermined program measures

Policy memoranda replete with support rationales when board decisions are required

Quarterly financial reports and budget reconciliations[xxiv]

The CCBOH selected quarterly statistical and narrative reports as its most preferred means to receive CUPHD regular progress accounts. It was clear from the discussion that the format of these quarterly reports should take the form of representations of pre-negotiated units of service established for the year, compared to actual performance for the current quarter and year-to-date. The identical data should be displayed for the previous year for comparison purposes. Each distinct program contained within the contract, and displayed within the budget, should be included in the reports envisioned. In addition, the administrator should provide an accompanying narrative that comments on trends within each of the program areas and advises the CCBOH of anticipated future trends.

The third and fourth selections were equally cited by the CCBOH as desirable reporting approaches. Policy memoranda would be required for any agenda item seeking CCBOH formal action. This would include action on grants, contracts, new services, and policy positions at a minimum. The memoranda would be prepared by the administrator with decision recommendations. The quarterly financial

statements are important in the opinion of the consultant. The current agreement only calls upon CUPHD to submit invoices that divide the proposed budget by 1/12th for payment by the CCBOH. The Board does not know the status of actual costs, by program, in relation to the budget or in relation to the prior year's experience. Providing the CCBOH with quarterly financial reports would keep it abreast of actual costs.

Although members did see value in monthly education presentations by CUPHD staff as a means of informing the Board of ongoing programs, it was seen as the least important of the four options offered. At the February Board of Health meeting, Environmental Health Director Jim Roberts presented an in-depth overview of the water well testing program. The depth of that presentation provided the CCBOH with an comprehensive understanding of the program's inputs and outputs and their relation to cost. A periodic reprise of such presentations might prove useful to the CCBOH in better understanding the program level detail and provide a more complete framework upon which to make future policy decisions.

As declared previously, the CCBOH is provided with projected costs in the CUPHD budget submission function for service delivery outside of the jurisdiction of CUPHD. Core programs are partially underwritten through county fees, property taxes, Local Health Protection Grant and other resources. The key services provided are infectious disease, food protection, potable water and private sewage disposal. Yet, the budget presented by CUPHD does not lay out cost centers for these specific services nor does it derive unit costs related to the programs. A budget template provided to the Champaign County Administrator sets forth an alternative budget development process that further delineates the budget for the upcoming fiscal year. Once in place, this format can be used to develop quarterly fiscal reports by program displaying quarterly and year-to-date revenue and expenditures measured against budget projections. Such reports should also show the identical information from the preceding year.

The combination of program and fiscal reports will provide the CCBOH with a snapshot of the public health programs being offered the residents of its jurisdiction and should become the basis upon which to evaluate progress from a process standpoint. A prime example of how this type of analysis can benefit the CCBOH took place in a neighboring county. The recent slump in real estate development caused a downturn in activity within the potable water and private sewage disposal programs. As a result, that department was able to leave a sanitarian position vacant without compromising services. The reduction in expenditures more than offset the shrinkage in program fees and resulted in a net savings to the organization during a time of fiscal constraints.

For verification purposes, and as part of the reporting process, it is recommended that CUPHD provide the CCBOH with documents from IDPH that support its status as a certified health department and compliance with other state standards. These documents would include: The letter approving its IPLAN, the letter rendering certification status, the letter approving the current incumbent as meeting state standards as CUPHD's administrator, a copy of the letter certifying compliance with LHPG standards and a copy of the completed LHPG review instrument. At least annually, CUPHD should provide the CCBOH with a copy of the inspection history for the past year for all establishments under the Board of Health's jurisdiction. This history would provide CCBOH with a breakdown of inspection frequency by type and their respective scores.

Evaluation of the Public Health Administrator:

As the response to the second interview question, the CCBOH believes that changes should be made regarding their role in evaluating the administrator. The contract is silent on how the CCBOH would exercise its role in this process. During 2010, there appeared to be insufficient time to generate a true board evaluation. Such a CEO performance evaluation customarily entails input from all board members and the development of a consensus performance evaluation by a committee. Often, such an evaluation

is discussed with the chief executive officer in executive session. In addition to its value as a reflection on past performance, executive evaluations have even more value as a tool to shape future performance. The end process should involve a merging of the administrator's personal objectives for the upcoming period coupled with the board's objectives for the incumbent. These processes generally involve, at a minimum, a quarterly or mid-term written report on progress toward meeting the objectives. Based upon a recent Champaign County State's Attorney's opinion, there does not appear to be any legal impediment under the current contract or state law to undertake such a more formal evaluation process.

Summary:

For the foreseeable future, the current contract for service model could be highly effective in meeting the needs of the citizens of Champaign County. The manner in which the agreement is carried out should be revisited. The contract design would be effective if the relationship between CUPHD and the CCBOH were merely one of a purchaser and provider of service. Both entities have public health authority over their respective jurisdictions. What should be of paramount interest in delivering services through the current agreement, or in whatever permutation future contracts take, is public health protection, prevention and promotion for all citizens of the county regardless of where they live. One CCBOH member summed up his comments by stating that a more collegial relationship needs to be developed. This is less about the nuts and bolts of the agreement and more about a cultural shift. Barriers need to be broken down and an atmosphere of enlightened self interest needs to prevail. The content of future contracts should be developed by board members in the interests of the citizens of the county. The context and format would be the only elements left to the party's respective legal counsel.

IX. Recommendations

The consultant's recommendations for the Champaign County Board of Health are broken down into short-term, mid-term and long-term efforts. Long-term and mid-term goals can be pursued while short-term goals are being developed and implemented. In essence, the recommendations can be pursued along parallel tracks.

Short-term Recommendation #1

Revise the current restructure the Board of Health agenda with the following design:

- Call to order
- Approval of agenda
- Approval of minutes
- Public participation
- Consent agenda (this would be approval of invoices and perfunctory actions)
- Old Business
  - Items for Action
  - Items for Discussion
- New Business
  - Items for Action
  - Items for Discussion
- Other Business - Board Issues
- Public Participation - non-agenda items
- Adjournment

The proposed structure would clearly separate items presented for board information from those requiring action. Old Business would be defined as any item previously discussed at a previous board meeting. New Business would entail anything not previously brought to the board for discussion or previous action. It is recommended that the revised agenda be put into place no later than July 1, 2010.

Short-term Recommendation #2

Adopt formal quarterly program and fiscal reports. The suggested design of those reports is set forth under the previous section under the heading of "Reporting:" Clearly identified program performance criteria needs to be determined by the Board of Health. Such production measures as permits issued, inspections conducted, disease investigations conducted, communicable diseases reported by disease category, et al. The data should compare actual performance against projections and against prior years achievements. It is recommended that the formats for these reports be developed no later than July 1, 2010 with the first reports presented for the quarter ending September 30, 2010. The CCBOH should also require copies of all evaluation instruments rendered by IDPH on programs being partially underwritten by the Board of Health. Similarly, the CCBOH should engage a representative to conduct periodic administrative compliance audits to assure actual staff allocation is consistent with approved budgets.

Short-term Recommendation #3

A formal performance evaluation process should to be established whereby the Champaign County Board of Health as a collective body evaluates the administrator. The results should be shared with the administrator in person, in closed session, and with the Champaign Urbana Health District Board of Health in writing. The weight of this evaluation, under the terms of the current contract, is at the sole discretion of the CUPHD. However, the Champaign Board of Health can begin a dialogue with the CUPHD board to determine where such an evaluation would fit in with the overall performance evaluation process. In addition to an assessment of the past year's performance, the evaluation should contain board developed objectives for the administrator to pursue for the upcoming year. Progress on achieving these objectives should be reviewed with the administrator at least once during the year prior at mid-year.

Short-term Recommendation #4

Explore the feasibility of establishing semi-annual joint study session meetings between the Champaign County Board of Health and the Champaign Urbana Public Health District Board of Health to discuss countywide public health priorities and issues and how the two organizations can better work in concert with one another. The formats of these meetings could entail discussions surrounding specific topics such as IPLAN priorities, locations for clinical services, pending state legislative issues impacting public health et al.

Mid-term Recommendation #1

Begin the negotiation process for the next contract period - beginning December 1, 2013 - no later than July 1, 2011. This should commence with consensus board objectives being developed as a prelude to entering into the negotiations for the next agreement. The current consensus points of the Champaign Board of Health are listed in the previous section. In essence, the Board of Health currently seeks a greater role in setting the policy agenda for defining the delivery of public health services in Champaign County. A consideration to include within a future contract is the concept of co-employment. Under this approach, both health department's would maintain employment status for shared employees on a proportionate basis. Another objective for the CCBOH is to establish a bi-lateral agreement. The potential debilitating aspects of involving the Champaign County Board as a party to the agreement is

mentioned within a previous section. Once consensus negotiating priorities are established, delegates from the Board of Health need to meet with the CUPHD board to begin developing the format for negotiations. Starting the process earlier would allow the Board of Health to determine whether or not their priorities are being addressed in the negotiations.

Mid-term Recommendation #2

Establish an *ad hoc* executive advisory body comprised of representatives of both boards. This could possibly be the forerunner of a permanent inter-department coordinating body. The role of this body would be to coordinate policy direction for recommended action by both boards. This could be an outgrowth of the negotiating process stated in Mid-term Recommendation #1 and result in the establishment of a virtual single health department.

Mid-term Recommendation #3

On a parallel track, begin exploring one of the alternative options for service delivery outlined in Section VIII. It is the consultant's view that both a countywide local health department and multiple county health departments are potential long-term options. As talked about, both of these options have a political dynamic that may require extensive negotiation and public policy marketing. The only viable mid-term option would be to pursue a standalone health department as presented within Section VIII. At a minimum, work would need to begin on establishing such a department by July 1, 2012. This would provide a seventeen month time-span to plan, recruit staff, engage in training, and have an entity in place by December 1, 2013. This option should be pursued only if contract negotiations do not result in acceptable preliminary contract progress for the upcoming period. If the standalone option is pursued, it would be necessary to involve the active cooperation of CUPHD to assist with the changeover and the Illinois Department of Public Health to transition services and provide for temporary dispensation of some certification and program standard compliance.

Long-term Recommendation #1

It is recommended that the Champaign County community pursue study of establishing a countywide local health department. The barriers to achieving this are clearly outlined within Section VIII of this report. The steps involved in pursuing this objective would include the establishment of an independent citizens task force or the involvement of a civic group such as the League of Women Voters to explore all facets involved in merging the operation of both departments under a single board of health. Following study, the citizens group would be charged with the responsibility of reporting its findings to the Champaign County Board, the Champaign County Board of Health, the Champaign Urban Public Health District Board of Health and the boards of supervisors for the two townships comprising CUPHD. If the recommendation is in favor of moving forward, the governmental bodies involved would need to consider resolutions to pursue a countywide local health department and begin the formal process of ceding authority and placing the appropriate referenda before the voters. If these steps meet with success, the Champaign Urbana Public Health Department would become the Champaign County Health Department.

As clearly outlined in Section VIII., a similar process consumed over a decade of political action in Springfield before a countywide department was established. Establishing a countywide local health department would place Champaign County in the mainstream of the delivery of public health services in Illinois. In order for such a movement to progress, parochial concerns will need to be set aside in favor of considering the public health needs of all county residents. The disparate parties in this process will need to adopt a mindset of enlightened self-interest. To succeed, all parties must see that the establishment of a countywide local health department is in the best interests of the public's health.

X. Conclusion

The consultant began working on this project in November of 2009. During the past six months an objective understanding of the inter-organizational dynamics of the relationship between the CCBOH and CUPHD began to unfold. Unequivocally, a cultural change is called for. Organizational culture is one of the most difficult aspects of any political or private entity to modify. Organizational culture is deeply rooted in history, past practices and the biases that develop over time. The structure and execution of the current intergovernmental agreement is an impediment to changing the existing culture. It perpetuates a clear organizational divide and fails to subordinate institutional interests in favor of community interests. The recommendations set forth in this report are intended to initially lend greater formality to the existing relationship for the purpose of clarifying procedural expectations for both parties and shifting focus to public health priorities and accountability. The report is designed to assist the board in plotting the course for the future form of local public health service delivery in the years after the current intergovernmental agreement expire and begin examining the establishment of a countywide public health jurisdiction. As this consultant has become invested in this process, it is sincerely hoped that the first step in this long journey will begin within months of this report.

XI. Acknowledgements

I wish to thank the following individuals for their special assistance during this process that ultimately led to the preparation of this report.

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Champaign County Administrative Secretary	Kat Bork
Champaign County Administrator	Deb Busey
McLean County Health Department Director	Walter Howe
CUPHD Administrator	Julie Pryde
CUPHD Director of Environmental Health	Jim Roberts
Champaign County Board of Health President	Julian Rappaport
DeWitt-Piatt Bi-County Health Department Administrator	David Remmert
Sangamon County Health Department Administrator	Jim Stone
Champaign County Mental Health Board Director	Peter Tracy

In addition, I wish to thank the members of the Champaign County Board of Health for their participation in the issues survey conducted during March and April of 2010.

NOTES

ATTACHMENT A

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER h: LOCAL HEALTH DEPARTMENTS
PART 600 CERTIFIED LOCAL HEALTH DEPARTMENT CODE
SECTION 600.100 STATEMENT OF PURPOSE

Section 600.100 Statement of Purpose

a) This Part has been developed by the Illinois Department of Public Health, in collaboration with the Illinois Association of Public Health Administrators, the Illinois Association of Boards of Health, the Illinois Public Health Association, and the University of Illinois School of Public Health. This Part sets forth requirements for local health departments to be certified by the Department and applies to all local health departments in the State that are conducting or intend to conduct and complete such requirements.

b) The Department is committed to the mission of public health – to fulfill society's interest in assuring conditions in which people can be healthy. Because of this commitment, the Department has the responsibility to assure that quality public health services are delivered to Illinois citizens. Where possible, it is in the best interest of Illinois citizens to have public health services delivered at the local level by a local health department. A Certified local health department is a local governmental agency that carries out the core functions of public health, assessment, policy development, and assurance, within its jurisdiction. Any local health department currently recognized by the Department will be eligible to seek certification. Performance of the core public health functions is the unique feature that distinguishes a Certified local health department from any other public health provider in a local area. The practice standards, included in this Part, are activities that demonstrate a local health department is fulfilling the core functions of public health.

c) Certification is an eligibility requirement for Local Health Protection Grants awarded by the Department. The Department will make other Department grants available to Certified local health departments, and the Department will give preference to Certified local health departments for certain grants.

Section 600.110 Definitions

For the purposes of this Part, the words and phrases defined herein shall have the following meanings:

"Certification" and "Certified" means certification granted to a local health department that meets the requirements set forth in Section 600.210 and Subparts C and D of this Part and is so designated by the Department.

"Community participation" means involvement by representatives of various community interests and groups. (Agency Note: Examples of such interests or groups are ethnic and racial groups, the medical community, mental health and social service organizations, the cooperative extension service, schools, law enforcement organizations, voluntary organizations, the clergy, the business community, economic development agencies, unions, disabled persons and senior citizens.)

"Contributing factor" means a scientifically established factor that directly affects the level of a risk factor.

"Department" means the Illinois Department of Public Health.

"Director" means the Director of the Illinois Department of Public Health or his designee.

"Essential Public Health Services" means the 10 services that describe the responsibilities of public health systems. A formulation of the processes used in public health to prevent epidemics and injuries, protect against environmental hazards, promote healthy behaviors, respond to disasters, and ensure quality and accessibility of health services, the essential public health services are:

monitor health status to identify community health problems;

diagnose and investigate health problems and health hazards in the community;

inform, educate, and empower people about health issues;

mobilize community partnerships to identify and solve health problems;

develop policies and plans that support individual and community health efforts;

enforce laws and regulations that protect health and ensure safety;

link people to needed personal health services and assure the provision of health care when otherwise unavailable;

assure a competent public and personal health care workforce;

evaluate effectiveness, accessibility and quality of personal and population-based health services; and

research for new insights and innovative solutions to health problems.

"Equivalent to IPLAN" means an assessment and planning process approved by the Department which meets the requirements set forth in Section 600.410.

"Healthy People 2000" means National Health Promotion and Disease Prevention Objectives, U.S. Department of Health and Human Services, Public Health Service, DHHS publication number (PHS) 91-50212. Healthy People 2000 contains a national strategy for significantly improving the health of the nation during this decade and contains measurable targets for striving toward health promotion and prevention of injuries and diseases.

"Impact objective" means a goal for the level to which a health problem should be reduced. An impact objective is intermediate in length of time and measurable.

"Indirect contributing factor" means a community-specific factor that directly affects the level of the direct contributing factors. These factors can vary greatly from community to community.

"IPLAN" means the Illinois Project for Local Assessment of Needs, a process developed by the Department to meet the requirements set forth in Section 600.410. IPLAN is a series of planning activities conducted within the local health department jurisdiction resulting in the development of an organizational capacity assessment, a community health needs assessment, and a community health plan.

"IPLAN Data System" means a data base developed by the Department that contains the required data sets to measure community health indicators for assessment purposes.

"Legally authorized representative" means the person empowered to act on behalf of the local health department and board of health in such matters as executing contracts, signing applications, and undertaking other major administrative tasks.

"Local health department" means a local governmental agency that administers and assures health-related programs and services within its jurisdiction.

"Local public health jurisdiction" means the geographic area over which a local board of health has legal and regulatory authority.

"Mandate" or "Mandated program" means those programs and activities that are statutorily required of local health departments by a legislative body, such as a city council, county board, or the General Assembly.

"Outcome objective" means a goal for the level to which a health problem should be reduced. An outcome objective is long term and measurable.

"Proven intervention strategy" means intervention strategy demonstrated to be effective or used as a national model.

"Provisional Certification" and "Provisionally Certified" means certification granted to a local health department that meets the requirements for Provisional Certification set forth in Section 600.200 and is so designated by the Department.

"Public health system" means the collection of public, private, and voluntary entities, as well as individuals and informal associations, that contribute to the delivery of essential public health services.

"Risk factor" means a scientifically established factor (determinant) that relates directly to the level of a health problem. A health problem may have any number of risk factors identified for it.

"Substantial compliance" means meeting the requirements set forth in this Part, except for variations from the strict and literal performance of such requirements which result in insignificant omissions and defects, given the particular circumstances and the incidence and history of such omissions and defects. Omissions and defects that have an adverse impact on public health and safety

shall not be considered insignificant and shall be considered substantial noncompliance.

(Source: Amended at 28 Ill. Reg. 8762, effective June 3, 2004)

Section 600.200 Provisional Certification

a) A local health department that serves one or more counties and that is not a Certified local health department may make application for Provisional Certification. Such application shall be submitted to the Department by letter, memorandum, or similar document signed by an authorized representative and shall include a written commitment to the Department to complete IPLAN or an equivalent to IPLAN within two years after Provisional Certification is granted.

b) Upon submission of a complete application, the Department shall have 60 days to review the application. Provisional Certification shall be granted by the Department to any local health department that meets subsection (a) of this Section. Provisional Certification shall expire upon Certification of the local health department or two years after the date Provisional Certification was granted, whichever is shorter. Provisional Certification may be renewed as provided in subsection (c) of this Section.

c) A local health department that has been granted Provisional Certification may apply for renewal of Provisional Certification. Such application shall be made at least 30 days prior to expiration of the Provisional Certification by submitting to the Department a letter, memorandum, or similar document signed by an authorized representative. The application shall describe activities that the local health department performed during the current term of Provisional Certification and future activities that will be undertaken during the renewal term that would be expected to result in the completion of IPLAN or an equivalent to IPLAN.

1) Renewal applications that are complete and received by the Department no later than 30 days prior to the expiration of Provisional Certification shall be considered by the Department.

2) The first renewal of Provisional Certification shall be made if the Department determines, on the basis of the application, that the applicant can be expected to complete IPLAN or an equivalent to IPLAN by conclusion of the renewal term.

3) The second renewal of Provisional Certification shall be made if the Department determines, on the basis of a written explanation submitted by

the local health department, in addition to the application for renewal specified in this subsection (c), that the applicant can be expected to complete IPLAN or an equivalent to IPLAN by conclusion of the second renewal term. The explanation shall include documentation of the incomplete elements of IPLAN or an equivalent to IPLAN with their expected completion dates and the reasons why the local health department did not complete IPLAN or an equivalent to IPLAN within the first renewal term.

4) A renewal of Provisional Certification granted by the Department shall not exceed 12 months.

5) No more than two renewals of Provisional Certification shall be granted to a local health department.

d) A provisionally Certified local health department is eligible to apply for a Local Health Department Development Grant, pursuant to the Department's Local Health Department Development Grant Rules (77 Ill. Adm. Code 610).

e) The Department may conduct an on-site review of the local health department and such documents necessary to determine substantial compliance with this Section.

(Source: Amended at 22 Ill. Reg. 14474, effective July 24, 1998)

Section 600.210 Certification

a) A Provisionally Certified local health department may apply for Certification.

1) Such application shall be submitted to the Department on forms or in a format provided or prescribed by the Department and shall include a community health needs assessment and a community health plan in accordance with Subpart D of this Part. The application shall be signed by an authorized representative.

2) Upon receipt of a complete application, the Department shall have 60 days to review the application to determine if the applicant meets the personnel requirements set forth in Subpart C of this Part and the practice standards set forth in Subpart D of this Part.

A) If the Department determines that the applicant is in substantial compliance with Subparts C and D of this Part, Certification shall be granted by the Department.

B) If the Department determines that the applicant is not in substantial compliance with Subparts C and D of this Part, Certification shall be denied and the local health department shall be notified in writing of the denial of Certification. Such notification shall specify the reasons for denial of Certification and shall describe the right of the applicant to request a hearing to appeal the denial of Certification, pursuant to Section 600.510.

b) Certification granted to local health departments that apply pursuant to this Section shall expire five years following the date of Certification.

1) All certifications set to expire in 2004 will be extended to the same date in 2005. These extensions will be granted automatically without the need for a waiver request. A petition to maintain the 2004 recertification schedule, however, may be submitted to the Department. The petition shall include the name of the local health department, a request to maintain the original recertification renewal date, and the signature of the public health administrator.

2) For the period between 2005 and 2007, the Department will implement a staggered certification renewal schedule in which approximately one third of local health departments will be reviewed annually. This review schedule will be developed by the Department in consultation with the local health departments. Thereafter, the certification reviews will occur every five years on this staggered schedule.

c) A Certified local health department may apply for renewal of Certification.

1) Such an application shall be made at least 60 days prior to the expiration of the Certification period. An application shall be submitted to the Department on forms or in a format provided or prescribed by the Department and shall include a community health needs assessment and a community health plan in accordance with Subpart D of this Part. The application shall be signed by an authorized representative.

2) Upon completion of a complete application, the Department shall have 60 days to review the application to determine if the applicant is in substantial compliance with the personnel requirements set forth in Subpart C of this Part and the practice standards set forth in Subpart D of this Part.

A) If the Department determines that the applicant is in substantial compliance with Subparts C and D of this Part, Certification shall be renewed by the Department for a five-year period.

B) If the Department determines that the applicant is not in substantial compliance with Subparts C and D of this Part, renewal of Certification shall be denied and the local health department shall be notified in writing of the denial of Certification. Such notification shall specify the reasons for denial of Certification and shall describe the right of the applicant to request a hearing to appeal the denial of Certification renewal, pursuant to Section 600.510.

d) A Certified local health department that at any time during the period for which the local health department has been granted Certification does not meet all applicable requirements for such Certification due to conditions or circumstances beyond the reasonable control of the local health department may make a written request to the Department for a waiver of the requirements set forth in Subparts C and D of this Part. A waiver will not be required for certification extensions issued under subsection (b) of this Section.

1) Conditions or circumstances beyond the reasonable control of the local health department shall include but not be limited to:

A) Unanticipated or unavoidable lack of qualified personnel necessary to fulfill applicable requirements; or

B) Disease outbreaks, natural disasters, and other unusual circumstances which may threaten the health and safety of residents and which require re-assignment of personnel to protect the health and safety of residents within the local health department's jurisdiction.

2) The Department shall grant a waiver if it determines that the local health department meets the conditions or circumstances specified in subsection (d)(1)(A) and (B) of this Section. The Department shall notify the local

health department of its decision within 10 working days after the receipt of the request.

A) A waiver shall be granted for a six-month period or until the conditions or circumstances referred to in subsections (d)(1)(A) and (B) of this Section are remedied, whichever is shorter.

B) 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.

i) The first extension of the waiver shall 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 substantial compliance with applicable requirements of Certification on or before the conclusion of the first extended waiver period.

ii) The second extension of waiver shall 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 substantial compliance with applicable requirements of Certification on or before the conclusion of the second extended waiver period. The explanation shall include documentation of the applicable Certification requirements that are not being met, with the expected dates for completion and the reasons why the local health department was unable to achieve substantial compliance within the first extension period.

3) The Department shall review the local health department for substantial compliance with Certification requirements upon the expiration of the waiver period or upon request of the local health department. The Department's review shall include only those certification requirements that are the basis for the waiver.

A) If the Department, based upon its review, determines that the local health department meets the requirements set forth in Subparts C and D of this Part, the local health department shall be considered

in substantial compliance with the requirements of Certification, and no further action shall be taken by the Department.

B) If the Department, based upon its review, determines that the local health department does not meet the requirements set forth in Subparts C and D of this Part and the waiver has expired, the Department shall notify the local health department of its option to request an extension of waiver under this Section.

C) If the Department, based upon its review, determines that the local health department does not meet the requirements set forth in Subparts C and D of this Part and the local health department's request was submitted prior to the expiration of the waiver period, the waiver shall continue until the end of the six-month period.

e) The Department may conduct an on-site review of the local health department and such documents necessary to determine substantial compliance with this Section.

(Source: Amended at 28 Ill. Reg. 8762, effective June 3, 2004)

Section 600.300 Executive Officer

a) A Certified local health department shall have an executive officer. The Department shall approve any individual as an executive officer of a local health department if the individual meets the minimum qualifications for either a Public Health Administrator set forth in Section 600.310 or Medical Health Officer as set forth in Section 600.320 and has been appointed as such by the board of health.

b) The local health department shall apply to the Department for approval of the qualifications of the individual who will serve as the local health department's executive officer.

c) Application for approval shall be made to the Department on the Personnel Information Form, which shall be provided by the Department.

d) The Department shall review the application and shall determine whether the applicant meets the requirements of this Subpart. An applicant shall be notified of the Department's determination, in writing, within 45 days of receipt of the complete application.

e) If the executive officer of the local health department is a Public Health Administrator, medical supervision shall be made available by the local board of

health as applicable. A physician licensed to practice medicine in all its branches in Illinois shall be available for consulting with the Public Health Administrator. The board of health shall maintain documentation of compliance with this subsection.

Section 600.310 Public Health Administrator

a) The Public Health Administrator shall possess, at a minimum, the following education and experience:

1) A master's degree in public health from a college or university accredited by the North Central Association or other regional, nationally-recognized accrediting agency and two years of full-time administrative experience in public health;

2) A graduate degree in a related field from a college or university accredited by the North Central Association or other regional, nationally-recognized accrediting agency, which may include but shall not be limited to a master's degree in public administration, nursing, environmental health, community health, health education, and two years of full-time administrative experience in public health; or

3) A bachelor's degree from a college or university accredited by the North Central Association or other regional, nationally-recognized accrediting agency, and four years of full-time administrative experience, of which at least two years must be in public health.

b) An incumbent Public Health Administrator, or a person who is acting in the capacity of a public health administrator as of the effective date of this Part, shall be considered in compliance with the education and experience requirements of subsection (a) of this Section and shall be exempt from the approval procedures specified in Section 600.300.

Section 600.320 Medical Health Officer

a) The Medical Health Officer shall possess, at a minimum, the following education and experience:

1) A master's degree in public health from a college or university accredited by the North Central Association or other regional, nationally-recognized accrediting agency or the equivalent experience in the health field, preferably public health;

2) A license to practice medicine in all of its branches in Illinois; and

3) Two years of full-time administrative experience in public health administration.

b) An incumbent Medical Health Officer, who has received approval by the Department and has been employed as a Medical Health Officer prior to the effective date of this Part, shall be considered in compliance with the education and experience requirements of subsection (a) of this Section, and shall be exempt from the approval procedures specified in Section 600.300.

c) Certification in Public Health by the American Board of Preventive Medicine or board certification in a related specialty is desirable but not required.

Section 600.330 Denial of Personnel Application

a) A local health department whose application for approval for an executive officer of a Certified or Provisionally Certified local health department has been denied shall have the right to request a hearing, pursuant to Section 600.510, contesting such denial.

b) Request for hearing pursuant to this Section shall be made in writing and shall contain a brief statement of the grounds upon which the request is made.

c) If a written hearing request is not received by the Department within 30 days after the receipt of the denial of application by the applicant, the right to a hearing is waived.

Section 600.400 Public Health Practice Standards

a) Assess the health needs of the community by establishing a systematic needs assessment process that periodically provides information on the health status and health needs of the community.

1) A community health needs assessment that systematically describes the prevailing health status and health needs of the population within the local health department's jurisdiction shall be conducted at least once every five years.

A) The assessment shall be conducted through completion of IPLAN or an equivalent to IPLAN that meets the requirements set forth in Section 600.410.

B) The assessment shall, at a minimum, include an analysis of data contained in the IPLAN Data System provided by the Department for assessment purposes.

C) The assessment shall include community participation in the health needs assessment process in order to facilitate the identification of community health problems and the setting of priorities from among those health problems.

D) Community health needs shall be identified during the community health needs assessment process based on the analysis of data describing the health of the population and on the judgment of the community participants concerning the seriousness of the health problems and needs. Prioritization shall result in the establishment of at least three priority health needs.

2) A community health needs assessment shall contain:

A) A statement of purpose of the community health needs assessment that includes a description of how the assessment will be used to improve health in the community.

B) A description of the community participation process, a list of community groups involved in the process, and method for establishing priorities.

C) A description of the health status and health problems most meaningful for the community in the data groupings designated by the Department in the IPLAN Data System.

D) A description of the process and outcomes of setting priorities.

b) Investigate the occurrence of adverse health effects and health hazards in the community by conducting timely investigations that identify the magnitude of health problems, duration, trends, location and populations at risk.

c) Advocate for public health, build constituencies and identify resources in the community by generating supportive and collaborative relationships with public and private agencies and constituent groups for the effective planning, implementation and management of public health activities. The local health department shall develop and strengthen communication with units of

government, health-related organizations, health providers, citizens, and news media;

1) The local health department shall meet at least annually with representatives of health-related organizations within its jurisdiction to define inter-organizational roles and responsibilities.

2) The local health department shall disseminate health reports that have been developed by the local health department to the board of health, county board or other legislative bodies within its jurisdiction, the media, and the public.

d) Develop plans and policies to address priority health needs by establishing goals and objectives to be achieved through a systematic course of action that focuses on local community needs and equitable distribution of resources, and involves the participation of constituents and other related governmental agencies. Develop a community health plan that addresses at least three priority health needs, identified pursuant to Section 600.400, during each certification period;

1) The local health department shall include in its community health plan an analysis to establish risk factors and contributing factors for each priority health need, to determine the adequacy of existing resources, and to identify population groups at risk of poor health status within the local health department's jurisdiction.

2) The community health plan shall present measurable objectives and strategies for intervention for each priority health need.

3) The local health department shall utilize community participation to assist in the development of the community health plan.

4) In jurisdictions where a board of health exists pursuant to Section 5-25012 of the Counties Code (Ill. Rev. Stat. 1991, ch. 34, par. 5-25012) [55 ILCS 5/5-25012]; Division 16 or 17 of the Illinois Municipal Code (Ill. Rev. Stat. 1991, ch. 24, par. 11-16-1 and par. 11-17-1 through 11-17-12) [65 ILCS 5/11-16-1 and 5/11-17]; or the Public Health District Act (Ill. Rev. Stat. 1991, ch. 111½, par. 0.01 et seq.) [70 ILCS 905], the local health department shall present the community health plan to the board of health for its review. A community health plan shall be adopted by the board of health.

5) The local health department shall submit the community health plan to the Department. The plan shall contain:

A) A statement of purpose of the community health plan that includes how the plan will be used to improve the health of the community;

B) A description of the process used to develop the community health plan;

C) A description of each priority including the importance of the priority health need, summarized data and information on which the priority is based, the relationship of the priority to Health People 2000 National Health Objectives and subsequent revisions and factors influencing the level of the problem (e.g., risk factors, contributing and indirect contributing factors);

D) At least one measurable outcome objective covering a five-year time frame related to each priority health need;

E) At least one measurable impact objective related to each outcome objective; and

F) At least one proven intervention strategy to address each impact objective. The description should include a discussion of: community resources that will contribute to implementation; estimated funding needed for implementation; and anticipated sources of funding.

e) Manage resources and develop organizational structure through the acquisition, allocation and control of human, physical and fiscal resources; and maximizing the operational functions of the local public health systems through coordination of community agencies' efforts and avoidance of duplication of services.

1) The local health department shall, at least once every five years, perform an organizational capacity self-assessment that meets the requirements set forth in Section 600.410. The local health department shall provide the Department with a statement signed by an authorized representative indicating that the organizational capacity self-assessment was completed by the local health department and reviewed by the board of health.

2) The local health department shall maintain a current organizational chart which includes all functional elements of the organization and their relationship to each other.

3) The local health department shall maintain current written job descriptions, minimum qualifications for each position, and written plans or policies regarding staff recruitment, selection, development, and retention.

f) Implement programs and other arrangements assuring or providing direct services for priority health needs identified in the community health plan by taking actions which translate plans and policies into services.

g) Evaluate programs and provide quality assurance in accordance with applicable professional and regulatory standards to ensure that programs are consistent with plans and policies, and provide feedback on inadequacies and changes needed to redirect programs and resources.

1) The local health department shall conduct periodic reviews of programs, services, and personnel to demonstrate compliance with applicable professional and regulatory standards.

2) The local health department shall conduct monitoring of programs to assess achievement of mandated programs and progress towards meeting community health objectives as stated in the community health plan.

h) Inform and educate the public on public health issues of concern in the community, promoting an awareness about public health services availability, and health education initiatives which contribute to individual and collective changes in health knowledge, attitudes and practices towards a healthier community.

i) Documentation of each activity conducted pursuant to Subpart D of this Part shall be available for review by the Department upon request.

Section 600.410 Requirements for IPLAN or an Equivalent Planning Process

a) IPLAN or a planning process equivalent to IPLAN shall meet the following requirements:

1) The process shall involve community participation in the identification of community health problems, priority-setting, and completion of the community health needs assessment and community health plan.

2) Community health indicators contained in the IPLAN Data System provided by the Department for assessment purposes or a similar, equally comprehensive data system developed by the local health department shall be utilized to structure the minimal content of the assessment. A local health department may use in its assessment such additional data available, describing the health of its population including natality, mortality, morbidity and risk factors for illness in its jurisdiction.

3) The process shall result in the setting of priority health needs.

4) The process shall include an analysis of priority problems that shall lead to the establishment of objectives and strategies for intervention.

5) The process shall include board of health adoption of the community health plan.

6) The process for developing an assessment of organizational capacity shall address:

A) the internal capabilities of the local health department to conduct effective public health functions, including an assessment of operational authority, community relations, information systems, and program management; or

B) an organizational strategic plan developed within the previous five years that assesses strengths, weaknesses, opportunities and threats in the local health jurisdiction.

b) Upon written request of a local health department, the Department shall approve a planning process equivalent to IPLAN if the Department determines that the proposed equivalent planning process complies with the requirements of subsection (a) of this Section. If the local health department is not satisfied with the Department's response to its request made pursuant to this subsection, it may petition the Director to reconsider.

Section 600.500 Denial, Suspension or Revocation of Certification

a) The Director, after notice and opportunity for hearing, may deny the application for Certification or suspend or revoke the Certification of any local health department in any case in which the Director finds substantial or continued failure to comply with this Part. If, however, the Director finds that the public interest, health, safety, or welfare requires emergency action and if the Director

incorporates a finding to that effect in the order, summary suspension of Certification may be ordered pending proceedings for revocation of Certification. Such proceedings shall be promptly instituted and promptly determined.

b) Such notice shall be made by certified mail or by personal service and shall set forth the particular reasons for the proposed action and provide the local health department with an opportunity to request a hearing. If a written hearing request is not received within 10 days after receipt of the notice by the local health department, the right to a hearing is waived.

(Source: Amended at 28 Ill. Reg. 8762, effective June 3, 2004)

Section 600.510 Procedures for Hearings

The Rules of Practice and Procedure in Administrative Hearings, 77 Ill. Adm. Code 100, shall apply to all proceedings conducted under this Part, with the exception that where the terms "license" and "licensing" are used in Part 100, the definitions of those terms shall be expanded to include Provisional Certification, and Certification as those term are defined in this Part.

ATTACHMENT B

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER h: LOCAL HEALTH DEPARTMENTS
PART 615 LOCAL HEALTH PROTECTION GRANT RULES
SECTION 615.100 DEFINITIONS

Section 615.100 Definitions

For purposes of this Part, the following definitions shall apply:

"Department" means the Illinois Department of Public Health.

"Director" means the Director of Public Health.

"Health Protection Program" means any program, service or activity performed by a local health department intended to prevent or reduce the incidence of disease, death or disability caused by infectious diseases; exposure to hazardous or toxic substances; or unsafe food, water, air, consumer products, or other environmental exposure.

"Healthy People 2000" means National Health Promotion and Disease Prevention Objectives, U.S. Department of Health and Human Services, Public Health Service, DHHS publication number (PHS) 91-50212. Healthy People 2000 contains a national strategy for significantly improving the health of the nation during this decade and contains measureable targets for striving toward health promotion and prevention of injuries and diseases.

"Local Health Protection Grant" means a grant made by the Department to a certified local health department for health protection programs including, but not limited to, Infectious Diseases, Food Protection, Potable Water Supply and Private Sewage Disposal.

"Substantial Compliance" means meeting requirements set forth in this Part, except for variations from the strict and literal performance of such requirements which result in insignificant omissions and defects, given the particular

circumstances and the incidence and history of such omissions and defects. Omissions and defects that have an adverse impact on public health and safety shall not be considered insignificant and shall be considered substantial noncompliance.

Section 615.110 Incorporated Materials

The following materials have been incorporated and referenced in this Part:

a) "Standards for Pediatric Immunization Practices" (February 1993), Centers for Disease Control and Prevention, Information Services Office, Mail Stop E-06, National Center for Prevention Services, Centers for Disease Control and Prevention, Atlanta GA 30333-4018.

b) "Sexually Transmitted Diseases Clinical Practice Guidelines" (May 1991), U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Atlanta GA 30333.

c) "Sexually Transmitted Diseases Treatment Guidelines" (September 1989), U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Atlanta GA 30333.

Section 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.

Section 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 Section 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)

Section 615.220 Review and Consultation; Plan of Correction

a) The Department 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.

b) Review and consultation shall be provided at least once every three (3) years, or as often as necessary, in order to assure substantial compliance with this Part and the local health department's grant agreement.

c) In the event the Department determines that a local health department is not in substantial compliance with the applicable rules and grant agreement, the local health department shall develop and follow a written plan of correction acceptable to the Department to achieve substantial compliance.

1) The Department shall notify the local health department of its determination in writing by means of a Notice of Noncompliance which specifies the areas of deficiency to be corrected.

2) A plan of correction shall be submitted to the Department within 30 days after receipt by the local health department of a Notice of Noncompliance.

3) If the local health department fails to submit a plan of correction that is acceptable to the Department, the Department may prescribe a plan of correction that shall be followed by the local health department, unless the local health department submits an alternative plan that is acceptable to the Department.

4) A local health department's failure to follow an approved or prescribed plan of correction shall be grounds for suspension or revocation of a grant agreement. Such action by the Department shall consider the local health department's degree of noncompliance with this Part, the duration of the noncompliance, the local health department's efforts to address the noncompliance, and the extent to which the noncompliance jeopardizes the public's health and safety.

Section 615.230 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.

Section 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)

Section 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)

Section 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 reinspection 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 under 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)

Section 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, 1988, 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 agreement.

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.

Section 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)

Section 615.400 Denial, Suspension or Revocation of Grant Application or Grant Agreement

a) The Director, after notice and opportunity for hearing, may deny the application for grant funds or suspend or revoke the grant agreement of any local health department in any case in which the Director finds substantial or continued failure to comply with this Part. If, however, the Director finds that the public interest, health, safety, or welfare requires emergency action and if the Director incorporates a finding to that effect in the order, summary suspension of a grant agreement may be ordered pending proceedings for revocation. Such proceedings shall be promptly instituted and promptly determined.

b) Such notice shall be made by certified mail or by personal service and shall set forth the particular reasons for the proposed action and provide the local health department with an opportunity to request a hearing. If a written hearing request is not received within 10 days after receipt of the notice by the local health department, the right to a hearing is waived.

Section 615.410 Procedures for Hearings

The Rules of Practice and Procedure in Administrative Hearings, 77 Ill. Adm. Code 100, shall apply to all proceedings conducted under this Part and any grant agreement executed pursuant to this Part.

Section 615.APPENDIX A Recommended Policies and Procedures for Immunization Clinics (Repealed)

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

ATTACHMENT C

COUNTIES
(55 ILCS 5/) Counties Code.

(55 ILCS 5/Div. 5-25 heading)
Division 5-25. County and Multi-county Health Departments

(55 ILCS 5/5-25001) (from Ch. 34, par. 5-25001)

Sec. 5-25001. County and multiple-county health departments. Any county or two or more adjacent counties may, by resolution of the county board or county boards of the respective counties, as the case may be, or upon approval by referendum as hereinafter provided, establish and maintain a full-time health department; provided, that four or more counties must obtain the approval of the State Department of Public Health prior to establishing a multiple-county health department. The approval may be obtained upon application by the county board of any county, containing such information as may be required by the State Department. Approval shall be granted if the State Department determines that the establishment of the multiple-county health department is essential to the health requirements of the area affected.

A "consolidated health department" shall mean a health department which has resulted from the merging of two or more adjacent existing county or multiple-county health departments, as provided in Section 5-25019.

A full-time health department is one whose personnel, other than consultants and clinicians, devote their full time during regular, standard working hours to health department duties. Reference hereinafter made to health departments means full-time health departments unless otherwise specified. (Source: P.A. 86-962.)

(55 ILCS 5/5-25002) (from Ch. 34, par. 5-25002)

Sec. 5-25002. Classification of departments. County and multiple county health departments established under this Division may be classified by the Director of Public Health in accordance with standards relating to programs, and performance. The State Department of Public Health is authorized to promulgate rules and regulations setting forth minimum standards for programs and performance, including regulations in which the State Department of Public Health shall require provision of home visitation and other services for pregnant women, new mothers and infants who are at risk as defined by that Department that encompass but are not limited to consultation for parental and child development, comprehensive health education, nutritional assessment, dental health, and periodic health screening, referral and follow-up; the services shall be provided through programs funded by

grants from the Department of Public Health from appropriations to the Department for that purpose. The Department is further authorized to prescribe minimum qualifications for the professional, technical, and administrative staff.
(Source: P.A. 86-962; 86-1377; 87-395.)

(55 ILCS 5/5-25003) (from Ch. 34, par. 5-25003)

Sec. 5-25003. Election on establishment of county health department and annual levy of additional tax. Whenever a petition signed by voters representing not less than 10% of the votes cast at the last preceding general election of any county is presented to the county clerk requesting the establishment and maintenance of a county health department and the levy therefor, in excess of the statutory limit, of an additional annual tax of not to exceed .1% of the value, as equalized or assessed by the Department of Revenue, of all taxable property of the county, the county clerk shall certify the proposition for submission at an election in accordance with the general election law, and the proposition shall be so submitted. The proposition shall be in substantially the following form:

Shall.... county levy an annual tax of not to exceed .1% for the purpose of providing community health facilities and services?	YES NO

If a majority of all votes cast upon the proposition is in favor thereof, the county board shall immediately proceed to establish a health department. In any county in which a county health department was established by a referendum prior to January 1, 1970, the county board may, by resolution and without subsequent referendum, levy a tax at a rate not to exceed the rate set forth in Section 5-25010. However, any levy in excess of .05% shall be approved by at least a three-fifths vote of the county board. The foregoing limitations upon tax rates, insofar as they are applicable to counties of less than 1,000,000 population, may be increased or decreased under the referendum provisions of the General Revenue Law of Illinois.
(Source: P.A. 86-962.)

(55 ILCS 5/5-25004) (from Ch. 34, par. 5-25004)

Sec. 5-25004. Election on establishment of multiple-county health department and annual levy of additional tax. Whenever a petition signed by voters representing not less than 10% of the votes cast at the last preceding general election in each of two or more adjacent counties is presented to their respective county clerks requesting the establishment and

maintenance of a multiple-county health department and the levy therefor, in excess of the statutory limit, of an additional annual tax in each county of not to exceed .1% of the value, as equalized or assessed by the Department of Revenue, of all taxable property of the county, each county clerk shall certify the proposition to the county clerk of each of the other counties mentioned in the petition. Each such county clerk in accordance with the general election law shall make certification to any board of election commissioners in his county and shall submit the proposition to the voters at an election. If the petitions are so presented in 4 or more counties, the approval of the State Department of Public Health as provided in Section 5-25001, shall be obtained prior to the giving of notice. The proposition shall be in substantially the following form:

Shall ... counties levy an annual tax of not to exceed .1% for the purpose of providing health facilities and services in their respective counties?	YES NO

If a majority of all votes cast upon the proposition in each county is in favor thereof, the several county boards shall immediately proceed to organize a multiple-county health department and shall agree concerning the conditions governing the organization and operation of the department and for the apportionment of the cost thereof. In any county in which a multiple county health department was established and organized by a referendum prior to January 1, 1970, the county board may, by resolution and without subsequent referendum, levy a tax at a rate not to exceed the rate set forth in Section 5-25010. However, any levy in excess of .05% shall be approved by at least a three-fifths vote of the county board. The foregoing limitations upon tax rates, insofar as they are applicable to counties of less than 1,000,000 population, may be increased or decreased under the referendum provisions of the General Revenue Law of Illinois.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25005) (from Ch. 34, par. 5-25005)

Sec. 5-25005. Canvass of votes. When the proposition is submitted to the voters of a county, the ballots shall be counted, the returns canvassed and the result declared as in the case of a regular county election.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25006) (from Ch. 34, par. 5-25006)

Sec. 5-25006. Canvass of votes in several counties. When the proposition is submitted to the voters of two or more adjacent counties, the ballots shall be counted and the returns made to the county clerk of each county, respectively, in the same manner as in the case of returns to the county

clerk in a general election. The returns shall be opened and canvassed by a committee made up of the county clerk of each county in which the vote on the proposition was cast, and the chairman of the county board of each county. The committee will convene at the request of the chairman of the county board of any one of the counties in which the vote on the proposition was cast. The committee shall elect a chairman whose duty it will be to see that the returns are opened and canvassed by the committee and that the result is declared.
(Source: P.A. 86-962.)

(55 ILCS 5/5-25007) (from Ch. 34, par. 5-25007)

Sec. 5-25007. County clerk to record vote. Each county clerk shall record the result of the vote upon the proposition in his county, and the result may be proved in all courts and in all proceedings by the record or by a certified copy thereof.
(Source: P.A. 86-962.)

(55 ILCS 5/5-25008) (from Ch. 34, par. 5-25008)

Sec. 5-25008. Jurisdiction of department. Each county and multiple-county health department has jurisdiction for the purposes of this Division throughout the entire county or multiple counties, except within:

1. Any public health district organized under "An Act to authorize the organization of public health districts and for the establishment and maintenance of a health department for the same," filed June 26, 1917, as amended;

2. Any city, village or incorporated town or combination thereof of less than 500,000 inhabitants which city, village, incorporated town or combination thereof or public health district maintains a local health department and employs a full-time health officer and other professional personnel possessing such qualifications as may be prescribed by the State Department of Public Health;

3. Any city, village or incorporated town of 500,000 or more inhabitants.
(Source: P.A. 86-962.)

(55 ILCS 5/5-25009) (from Ch. 34, par. 5-25009)

Sec. 5-25009. Abandonment of city, village or town department. Any city, village or incorporated town, or combination thereof or any public health district which maintains its own independent health department may abandon the same and become integrated in the county or multiple-county health department. The method of abandonment, unless otherwise prescribed by law, shall be the same as the method of adoption. Abandonment shall become effective at the end of the fiscal year of the city, village, incorporated town or public health district.

Any county which establishes a county health department may unite with other counties to organize a multiple-county

health department, in which event the county health department shall be dissolved as soon as the multiple-county health department is organized and all of its records shall be transferred to the multiple-county health department. (Source: P.A. 86-962.)

(55 ILCS 5/5-25010) (from Ch. 34, par. 5-25010)

Sec. 5-25010. Annual tax levy. The county board of any county which has established and is maintaining a county or multiple-county health department shall, when authorized as provided in Sections 5-25003 or 5-25004, levy annually therefor, in excess of the statutory limit, a tax of not to exceed .1% of the value plus the additional tax, if applicable, provided for in Section 5-23002, or plus the additional tax, if applicable, provided for in Section 5.3 of "An Act to provide for the creation and management of tuberculosis sanitarium districts", approved May 21, 1937, as now or hereafter amended, as equalized or assessed by the Department of Revenue, of all taxable property of the county, which tax shall be levied and collected in like manner as general county taxes and shall be paid (except as provided in Section 5-25011) into the county treasury and held in the County Health Fund and shall be used only for the purposes of this Division. Where there is a county health department, the County Health Fund shall be drawn upon by the proper officers of the county upon the properly authenticated vouchers of the county health department. Where there is a multiple-county health department, the County Health Fund shall be drawn upon by the treasurer of the board of health of the multiple-county health department. In counties maintaining single county health departments, each county board shall appropriate from the County Health Fund such sums of money as may be sufficient to fund the approved budget of the county health department, so long as those sums have been set out in the annual budget submitted to the county board by the county board of health and that annual budget has been approved by the county board. In counties with a population between 700,000 and 3,000,000, the county board chairman has the power to veto or reduce any line item in the appropriation ordinance for the county or multiple-county health department as provided in Section 5-1014.5. Each county board of counties participating in the maintenance of a multiple-county health department shall appropriate from the County Health Fund and shall authorize the county treasurer to release quarterly or more often to the treasurer of the board of health of the multiple-county health department such sums of money as are in accordance with the budget submitted by the multiple-county board of health and approved by the county board of each of the participating counties as may be necessary to pay its agreed share for the maintenance of the multiple-county health department. The treasurer of the board of health of the multiple-county health department shall request by voucher, quarterly or more often

such sums of money from the county treasurers of the respective member counties, and shall support such requests with estimates of anticipated receipts and expenditures for the period for which sums of money are requested and with statements of receipts and expenditures for the preceding period. In addition, that treasurer shall support the requests to the annual budget submitted by the multiple-county public health board and approved by the county board of each of the participating counties. No payment may be made from a County Health Fund except on the basis of a budget item in a budget submitted by the appropriate public health board and approved by the county board or boards concerned; however, amended or supplemental budgets may be submitted and approved and thereby be the basis for such a payment.
(Source: P.A. 89-402, eff. 8-20-95.)

(55 ILCS 5/5-25011) (from Ch. 34, par. 5-25011)

Sec. 5-25011. Disposition of taxes collected. The entire amount collected from taxes levied under this Division on property subject to the general corporate tax of any city, village or incorporated town or combination thereof or public health district which maintains its own local health department as provided in this Division, less the amount allowed for collecting the same, shall be paid over by the county treasurer to the treasurer of the public health district, city, village or incorporated town to be used for the maintenance of its local health department.
(Source: P.A. 86-962.)

(55 ILCS 5/5-25012) (from Ch. 34, par. 5-25012)

Sec. 5-25012. Board of health. Except in those cases where a board of 10 or 12 members is provided for as authorized in this Section, each county health department shall be managed by a board of health consisting of 8 members appointed by the president or chairman of the county board, with the approval of the county board, for a 3 year term, except that of the first appointees 2 shall serve for one year, 2 for 2 years, 3 for 3 years and the term of the member appointed from the county board, as provided in this Section, shall be one year and shall continue until reappointment or until a successor is appointed. Each board of health which has 8 members, may have one additional member appointed by the president or chairman of the county board, with the approval of the county board. The additional member shall first be appointed within 90 days after the effective date of this amendatory Act for a term ending July 1, 2002.

The county health department in a county having a population of 200,000 or more may, if the county board, by resolution, so provides, be managed by a board of health consisting of 12 members appointed by the president or chairman of the county board, with the approval of the county board, for a 3 year term, except that of the first appointees 3 shall serve for one year, 4 for 2 years, 4 for 3 years and the term of the member appointed from the county board, as provided in this Section, shall be one year and shall continue until reappointment or until a successor is appointed. In counties

with a population of 200,000 or more which have a board of health of 8 members, the county board may, by resolution, increase the size of the board of health to 12 members, in which case the 4 members added shall be appointed, as of the next anniversary of the present appointments, 2 for terms of 3 years, one for 2 years and one for one year.

The county board in counties with a population of more than 100,000 but less than 3,000,000 inhabitants and contiguous to any county with a metropolitan area with more than 1,000,000 inhabitants, may establish compensation for the board of health, as remuneration for their services as members of the board of health. Monthly compensation shall not exceed $200 except in the case of the president of the board of health whose monthly compensation shall not exceed $400.

When a county board of health consisting of 8 members assumes the responsibilities of a municipal department of public health, and both the county board and the city council adopt resolutions or ordinances to that effect, the county board may, by resolution or ordinance, increase the membership of the county board of health to 10 members. The additional 2 members shall initially be appointed by the mayor of the municipality, with the approval of the city council, each such member to serve for a term of 2 years; thereafter the successors shall be appointed by the president or chairman of the county board, with the approval of the county board, for terms of 2 years.

Each multiple-county health department shall be managed by a board of health consisting of 4 members appointed from each county by the president or chairman of the county board with the approval of the county board for a 3 year term, except that of the first appointees from each county one shall serve for one year, one for 2 years, one for 3 years and the term of the member appointed from the county board of each member county, as hereinafter provided, shall be one year and shall continue until reappointment or until a successor is appointed.

The term of office of original appointees shall begin on July 1 following their appointment, and the term of all members shall continue until their successors are appointed. All members shall serve without compensation but may be reimbursed for actual necessary expenses incurred in the performance of their duties. At least 2 members of each county board of health shall be physicians licensed in Illinois to practice medicine in all of its branches and at least one member shall be a dentist licensed in Illinois. In counties with a population under 500,000, one member shall be chosen from the county board or the board of county commissioners as the case may be. In counties with a population over 500,000, two members shall be chosen from the county board or the board of county commissioners as the case may be. At least one member from each county on each multiple-county board of health shall be a physician licensed in Illinois to practice medicine in all of its branches, one member from each county on each multiple-county board of health shall be chosen from the county board or the board of county commissioners, as the case may be, and at least one member of the board of health shall be a dentist licensed in Illinois. Whenever possible, at least one member shall have experience in the field of mental health. All members shall be chosen for their special fitness for membership on the board.

Any member may be removed for misconduct or neglect of duty by the chairman or president of the county board, with the approval of the county

board, of the county which appointed him.

Vacancies shall be filled as in the case of appointment for a full term.

Notwithstanding any other provision of this Act to the contrary, a county with a population of 240,000 or more inhabitants that does not currently have a county health department may, by resolution of the county board, establish a board of health consisting of the members of such board. Such board of health shall be advised by a committee which shall consist of at least 5 members appointed by the president or chairman of the county board with the approval of the county board for terms of 3 years; except that of the first appointees at least 2 shall serve for 3 years, at least 2 shall serve for 2 years and at least one shall serve for one year. At least one member of the advisory committee shall be a physician licensed in Illinois to practice medicine in all its branches, at least one shall be a dentist licensed in Illinois, and one shall be a nurse licensed in Illinois. All members shall be chosen for their special fitness for membership on the advisory committee.

All members of a board established under this Section must be residents of the county, except that a member who is required to be a physician, dentist, or nurse may reside outside the county if no physician, dentist, or nurse, as applicable, who resides in the county is willing and able to serve. (Source: P.A. 94-457, eff. 1-1-06; 94-791, eff. 1-1-07.)

(55 ILCS 5/5-25013) (from Ch. 34, par. 5-25013)

Sec. 5-25013. Organization of board; powers and duties.

(A) The board of health of each county or multiple-county health department shall, immediately after appointment, meet and organize, by the election of one of its number as president and one as secretary, and either from its number or otherwise, a treasurer and such other officers as it may deem necessary. A board of health may make and adopt such rules for its own guidance and for the government of the health department as may be deemed necessary to protect and improve public health not inconsistent with this Division. It shall:

1. Hold a meeting prior to the end of each operating fiscal year, at which meeting officers shall be elected for the ensuing operating fiscal year;

2. Hold meetings at least quarterly;

3. Hold special meetings upon a written request signed by two members and filed with the Secretary or on request of the medical health officer or public health administrator;

4. Provide, equip and maintain suitable offices, facilities and appliances for the health department;

5. Publish annually, within 90 days after the end of the county's operating fiscal year, in pamphlet form, for free distribution, an annual report showing the condition of its trust on the last day of the most recently completed operating fiscal year, the sums of money received from all sources, giving the name of any donor, how all moneys have been expended and for what purpose, and such other statistics and information in regard to the

work of the health department as it may deem of general interest;

6. Within its jurisdiction, and professional and technical competence, enforce and observe all State laws pertaining to the preservation of health, and all county and municipal ordinances except as otherwise provided in this Division;

7. Within its jurisdiction, and professional and technical competence, investigate the existence of any contagious or infectious disease and adopt measures, not inconsistent with the regulations of the State Department of Public Health, to arrest the progress of the same;

8. Within its jurisdiction, and professional and technical competence, make all necessary sanitary and health investigations and inspections;

9. Upon request, give professional advice and information to all city, village, incorporated town and school authorities, within its jurisdiction, in all matters pertaining to sanitation and public health;

10. Appoint a medical health officer as the executive officer for the department, who shall be a citizen of the United States and shall possess such qualifications as may be prescribed by the State Department of Public Health; or appoint a public health administrator who shall possess such qualifications as may be prescribed by the State Department of Public Health as the executive officer for the department, provided that the board of health shall make available medical supervision which is considered adequate by the Director of Public Health;

10 1/2. Appoint such professional employees as may be approved by the executive officer who meet the qualification requirements of the State Department of Public Health for their respective positions provided, that in those health departments temporarily without a medical health officer or public health administrator approval by the State Department of Public Health shall suffice;

11. Appoint such other officers and employees as may be necessary;

12. Prescribe the powers and duties of all officers and employees, fix their compensation, and authorize payment of the same and all other department expenses from the County Health Fund of the county or counties concerned;

13. Submit an annual budget to the county board or boards;

14. Submit an annual report to the county board or boards, explaining all of its activities and expenditures;

15. Establish and carry out programs and services in mental health, including mental retardation and alcoholism

and substance abuse, not inconsistent with the regulations of the Department of Human Services;

16. Consult with all other private and public health agencies in the county in the development of local plans for the most efficient delivery of health services.

(B) The board of health of each county or multiple-county health department may:

1. Initiate and carry out programs and activities of all kinds, not inconsistent with law, that may be deemed necessary or desirable in the promotion and protection of health and in the control of disease including tuberculosis;

2. Receive contributions of real and personal property;

3. Recommend to the county board or boards the adoption of such ordinances and of such rules and regulations as may be deemed necessary or desirable for the promotion and protection of health and control of disease;

4. Appoint a medical and dental advisory committee and a non-medical advisory committee to the health department;

5. Enter into contracts with the State, municipalities, other political subdivisions and non-official agencies for the purchase, sale or exchange of health services;

6. Set fees it deems reasonable and necessary (i) to provide services or perform regulatory activities, (ii) when required by State or federal grant award conditions, (iii) to support activities delegated to the board of health by the Illinois Department of Public Health, or (iv) when required by an agreement between the board of health and other private or governmental organizations, unless the fee has been established as a part of a regulatory ordinance adopted by the county board, in which case the board of health shall make recommendations to the county board concerning those fees. Revenue generated under this Section shall be deposited into the County Health Fund or to the account of the multiple-county health department.

7. Enter into multiple year employment contracts with the medical health officer or public health administrator as may be necessary for the recruitment and retention of personnel and the proper functioning of the health department.

(C) The board of health of a multiple-county health department may hire attorneys to represent and advise the department concerning matters that are not within the exclusive jurisdiction of the State's Attorney of one of the counties that created the department.

(Source: P.A. 89-272, eff. 8-10-95; 89-507, eff. 7-1-97.)

(55 ILCS 5/5-25014) (from Ch. 34, par. 5-25014)

Sec. 5-25014. Prompt payment. Purchases made pursuant to this Division shall be made in compliance with the "Local Government Prompt Payment Act".

(Source: P.A. 86-962.)

(55 ILCS 5/5-25015) (from Ch. 34, par. 5-25015)

Sec. 5-25015. Officers and employees. Each county or multiple-county health department shall have the exclusive right to employ and discharge its officers and employees, except as otherwise provided in Section 5-25013; provided that in counties having a civil service system, the employees of the health department shall be subject to the rules and regulations of such system.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25016) (from Ch. 34, par. 5-25016)

Sec. 5-25016. Lease or acquisition of property for department. The board of health of each county or multiple-county health department is authorized to lease or to acquire by purchase, construction, lease-purchase agreement or otherwise and take title in its name and to borrow money, issue debt instruments, mortgages, purchase money mortgages and other security instruments, maintain, repair, remodel or improve such real estate as may be reasonably necessary for the housing and proper functioning of such health department. Money in the County Health Fund may be used for such purposes.

Upon the discontinuance of a single county health department any such real estate shall become the property of and title shall be transferred to the county.

Upon the discontinuance of a multiple-county health department any such real estate shall be sold and the proceeds distributed pro-rata to the several counties as their agreed share of the maintenance of such department may indicate.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25017) (from Ch. 34, par. 5-25017)

Sec. 5-25017. Discontinuance of department. Any health department may be discontinued; 1 - by resolution of the county board or county boards, if established in such manner; or, 2 - if established by referendum, then by a referendum initiated by petition and submitted to vote in the same manner as for adoption. The proposition shall be stated "For the discontinuance of the county (or multiple-county) health department" and "Against the discontinuance of the county (or multiple-county) health department." If a majority of the votes cast upon the proposition in any county is for discontinuance, the board of health shall proceed at once to close up the affairs of the department. After the payment of all obligations, the money in the "County Health Fund" shall become a part of the general funds in the county treasury. All other property shall be devoted to such county purpose as the county board or boards determine.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25018) (from Ch. 34, par. 5-25018)

Sec. 5-25018. Board of Health in counties having civil service qualifications and appointment. When this Division is adopted by resolution in counties over 500,000 population where Civil Service Qualifications and appointment on all employees prevail, and where all funds expended are approved by budget of the County Board of Commissioners and so paid after approval, by the County Treasurer, the County Board of Commissioners shall constitute the Board of Health to carry out the provisions of this Division in a similar manner to other acts and duties of the County.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25019) (from Ch. 34, par. 5-25019)

Sec. 5-25019. Formation of consolidated health department. Any county which has established a county health department or any counties which have established a multiple-county health department may unite with one or more adjacent counties which have established county or multiple-county health departments, for the purpose of maintaining and operating a consolidated health department subject to the approval of the county boards involved and the Director of the Illinois Department of Public Health. In the event of approval by the county boards involved and the Director of Public Health, the chairman or president of each county board and of each board of health shall meet and immediately proceed to organize the consolidated health department. At such time as they shall agree concerning the conditions governing organization and operation, and the apportionment of the costs thereof, they shall select a date within 60 days on which the consolidated health department shall be established, and its operation and maintenance shall be in accordance with all provisions of this Division relating to county health departments except where otherwise prescribed for multiple-county health departments. The county or multiple-county health departments in counties joining together to operate and maintain a consolidated health department shall cease to function as independent health departments so long as the consolidation shall exist; shall transfer all records to the consolidated health department; and shall not withdraw from this union except in accordance with the provisions of Section 5-25020.

The board of health of each consolidated health department shall consist of the members of the boards of health of the county and multiple-county health departments involved except that members from counties which have previously established single county health departments shall be reduced to four, including at least one physician and one member of the county board. New appointments and reappointments shall be made in accordance with the provisions of Section 5-25012 relating to boards of health of multiple-county health departments. The consolidated board of health shall hold its first meeting no later than seven days after the date of establishment, for the

purpose of organizing, electing officers, and carrying out its responsibilities in connection with the consolidated health department. Its subsequent meetings shall be held as prescribed in this Division for multiple-county health departments. Membership and actions of the consolidated board of health shall become official at its first meeting or on the date of establishment of the consolidated health department, whichever occurs at the earlier date. After a consolidated health department has begun operation, addition of other health departments to the consolidation may be accomplished with consent of all county boards of supervisors or commissioners concerned and the Director of Public Health; participation by such additional counties will be under the conditions selected in the original consolidation agreement, and date of entry into the consolidation and other relevant details will be arranged between the board of health of the consolidated health department, and the president of the county board and the chairman or president of the board of health of each county requesting admission to the consolidated health department.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25020) (from Ch. 34, par. 5-25020)

Sec. 5-25020. Withdrawal from consolidated health department. Any county which has established a county health department or counties which have established a multiple-county health department may withdraw from a consolidated health department for the purpose of maintaining and operating an independent county or multiple-county health department, as the case may be, or for the purpose of joining with another adjacent county or other adjacent counties in maintaining and operating a consolidated health department. Withdrawal for such purposes may be effected by majority vote of the county board of the withdrawing county which had established a county health department, or by a majority vote of each county board of the withdrawing counties which had established a multiple-county health department, before joining the consolidated health department. In all withdrawals from consolidated health departments, the county board of each county proposing withdrawal shall seek the advice and concurrence of the Director of the Illinois Department of Public Health before taking action effecting withdrawal. The effective date of withdrawal shall be June 30 following completion of the withdrawal agreements. The board of health of the consolidated health department shall meet and the members of the withdrawing and the remaining counties shall agree upon removal of records, supplies, equipment and personnel by the withdrawing county or counties. Withdrawal of any county or counties from the consolidated health department does not alter the consolidation if the county or multiple-county health departments remaining party to the union are two or more. Discontinuance of any county or

multiple-county health department effected under the provisions of Section 5-25017 constitutes withdrawal from a consolidated health department.

Any county which is a member county of a consolidated health department may also withdraw from the consolidated health department upon approval by referendum, the proposition for which shall be placed on the ballot at any general election by the county clerk on receipt of a petition signed by not less than 10 per cent of the registered voters of the county. The proposition shall be certified to the proper election officials, who shall submit the proposition to the voters at an election in accordance with the general election law. The proposition shall read substantially as follows:

Shall .... county withdraw the county health department from the ..... consolidated health department?	YES NO

If a majority of voters favor withdrawal the county shall arrange its withdrawal effective June 30 following the referendum and shall settle its affairs in the consolidated health department and resume operation in the manner hereinbefore prescribed in this section.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25021) (from Ch. 34, par. 5-25021)

Sec. 5-25021. Bonds for permanent improvements; referendum. Whenever the county board determines that it is necessary to issue bonds to enable it to provide buildings for or to make permanent improvements in the community health facilities, the county board shall so instruct the county clerk. Thereupon, such clerk shall certify such determination to the proper election officials, who shall submit the proposition at an election in accordance with the general election law.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25022) (from Ch. 34, par. 5-25022)

Sec. 5-25022. Form of proposition. The proposition pursuant to Section 5-25021 shall be in substantially the following form:

Shall.... county issue bonds to the amount of.... dollars for the purpose of enabling the county to.... (purpose to be stated, which shall be either to provide buildings for or to make permanent improvements in the community health facilities)?	YES NO

In case a majority of the votes cast upon the propositions shall be in favor of the issuance of such bonds, the county board shall issue the bonds not exceeding the amount

authorized at the referendum. Such bonds shall become due not more than 20 years after their date, shall be in denominations of $100 or any multiple thereof, and shall bear interest, evidenced by coupons, at a rate not exceeding the maximum rate authorized by the Bond Authorization Act, as amended at the time of the making of the contract, payable semi-annually, as shall be determined by the county board.

With respect to instruments for the payment of money issued under this Section or its predecessor either before, on, or after the effective date of Public Act 86-4, it is and always has been the intention of the General Assembly (i) that the Omnibus Bond Acts are and always have been supplementary grants of power to issue instruments in accordance with the Omnibus Bond Acts, regardless of any provision of this Division or "An Act in relation to the establishment and maintenance of county and multiple-county public health departments", approved July 9, 1943, that may appear to be or to have been more restrictive than those Acts, (ii) that the provisions of this Section or its predecessor are not a limitation on the supplementary authority granted by the Omnibus Bond Acts, and (iii) that instruments issued under this Section or its predecessor within the supplementary authority granted by the Omnibus Bond Acts are not invalid because of any provision of this Division or "An Act in relation to the establishment and maintenance of county and multiple-county public health departments", approved July 9, 1943, that may appear to be or to have been more restrictive than those Acts.

(Source: P.A. 86-962; 86-1028.)

(55 ILCS 5/5-25023) (from Ch. 34, par. 5-25023)

Sec. 5-25023. Sale of bonds. The bonds authorized by this Division shall be sold and the proceeds thereof used solely for the specified purpose. At or before the time of delivery of any bond, the county board shall file with the county its certificates, stating the amount of bonds to be issued, or denominations, rate of interest, where payable, and shall include a form of bond to be issued. The county board shall levy a direct tax upon all of the taxable property within the county sufficient to pay the principal and interest on the bonds as and when the same respectively mature. Such tax shall be in addition to all other taxes and shall not be within any rate limitation otherwise prescribed by law.

The proceeds received from the sale of the bonds shall be placed in a special fund in the county treasury to be designated as the "Bond Community Health Fund" and thereafter the county shall appropriate from such funds such sum or sums as may be necessary to carry out the provisions of this Section.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25024) (from Ch. 34, par. 5-25024)

Sec. 5-25024. Submission at same election. Both the

proposition for the levy of an annual tax pursuant to Sections 5-25003 or 5-25004 and the proposition for issuance of bonds pursuant to Section 5-25021 may be submitted to the electors at the same election.
(Source: P.A. 86-962.)

(55 ILCS 5/5-25025) (from Ch. 34, par. 5-25025)

Sec. 5-25025. Mental health program. If the county board of any county having a population of less than 1,000,000 inhabitants and maintaining a county health department under this Division desires the inclusion of a mental health program in that county health department and the authority to levy the tax provided for in subsection (c) of this Section, the county board shall certify that question to the proper election officials, who shall submit the proposition at an election in accordance with the general election law. The proposition shall be in substantially the following form:

Shall .....County include a mental health program in the county health department, and levy an annual tax of not to exceed .05% of the value of all taxable property for use for mental health purposes by the county health department?	YES --- NO

If a majority of the electors voting at that election vote in favor of the proposition, the county board may include the mental health program in the county health department and may, annually, levy the additional tax for mental health purposes. All mental health facilities provided shall be available to all citizens of the county, but the county health board may vary any charges for services according to ability to pay.

When the inclusion of a mental health program has been approved:

(a) To the extent practicable, at least one member of the County Board of Health, under Section 5-25012, shall be a person certified by The American Board of Psychiatry and Neurology professionally engaged in the field of mental health and licensed to practice medicine in the State, unless there is no such qualified person in the county.

(b) The president or chairman of the county board of health shall appoint a mental health advisory board composed of not less than 9 nor more than 15 members who have special knowledge and interest in the field of mental health. Initially, 1/3 of the board members shall be appointed for terms of one year, 1/3 for 2 years and 1/3 for 3 years. Thereafter, all terms shall be for 3 years. This advisory board shall meet at least twice each year and provide counsel, direction and advice to the county board of health in the field of mental health.

(c) The county board may levy, in excess of the statutory limit and in addition to the taxes permitted under Sections 5-25003, 5-25004 and 5-25010, an additional annual tax of not more than .05% of the value, as equalized or assessed by the Department of Revenue, of all taxable property within the county which tax shall be levied and collected as provided in Section 5-25010 but held in the County Health Fund of the county treasury for use for mental health purposes. These funds may be used to provide care and treatment in public and private mental health facilities.

(d) When a mental health program has been included in a county health department pursuant to this Section, the county board may obtain the authority to levy a tax for mental health purposes in addition to the tax authorized by the preceding paragraphs of this Section but not in excess of an additional .05% of the value, as equalized or assessed by the Department of Revenue, of all taxable property in the county by following the procedure set out in Section 5-25003 except that the proposition shall be in substantially the following form:

Shall.... county levy, in excess of the statutory limit, an additional annual tax of not to exceed .05% for use for mental health purposes by the county health department?

YES

NO

If the majority of all the votes cast on the proposition in the county is in favor thereof, the county board shall levy such tax annually. The levy and collection of this tax shall be as provided in Section 5-25010 but the tax shall be held in the County Health Fund of the county treasury for use, with that levied pursuant to paragraph (c), for mental health purposes.

(Source: P.A. 86-962; 86-1028.)

(55 ILCS 5/5-25026)

Sec. 5-25026. Locally grown foods. Except in emergency situations, including but not limited to a food-borne disease outbreak, the board of health of a county or multi-county health department may not discourage the purchase or consumption of locally grown foods in relation to foods that are not locally grown.

(Source: P.A. 96-620, eff. 8-24-09.)

Attachment D is the proforma budget for a standalone local health department as described within the accompanying report

Champaign County Board of Health Budget Template	DO NOT ENTER Non - DHS Total Overall CCHD	ENTER Tobacco Grant Tobacco Free	ENTER Emer Prep Grant Emer Prep	ENTER WNV Grant WNV	ENTER H1N1 SRV Grant H1n1 SRV	ENTER H1N1 Pdl Grant H1N1 Pdl III	DO NOT ENTER Grant Total Grant Programs	ENTER Admin IHPG Administration	ENTER Inf Dis IHPG Infectious Dis	ENTER Food LHPG Food Protection	ENTER Temp Food IHPG Temp Food	ENTER Pvt Sewage LHPG Private Sewage	ENTER Potable H2O IHPG Potable Water	ENTER Aban Well IHPG Aban Well	ENTER Well Test Water Well Testing
Revenue															
Property Taxes	$382,893						$0	$176,124	$192,392		$9,177	$4,452	$6,743		
Food Permits	$98,750						$0			$98,750					
Temporary Food Permits	$3,000						$0				$3,000				
Private Sewage Permits	$33,000						$0					$33,000			
Well Testing Fees	$8,277						$0								$8,277
Well Water Permits	$5,500						$0						$5,500		
Vital Records Fees	$0						$0								
EPA Pub Water System Supv	$0						$0								
IDPH Emergency Preperation Grant	$64,000		$64,000				$64,000								
DHS Family Case Mgt	$0						$0								
DHS EFP	$0						$0								
DHS WIC Grant	$0						$0								
IDPH - Local Health Protection Grant - Yellow Fields Only	$125,560						$0	$10,043	$3,557	$29,033	$3,000	$41,802	$26,105	$12,260	
IDPH WNV Vector Control Grant	$7,950			$7,950			$7,950								
IDPH Tobacco Free Grant	$25,777	$25,777					$25,777								
IDHFS (Medicaid)	$0						$0								
Other grants and contracts(Medicaid)	$54,000						$0		$54,000						
Other Income	$0						$0								
Interest Income	$4,000						$0	$4,000							
TOTAL REVENUE	**$812,707**	**$25,777**	**$64,000**	**$7,950**	**$0**	**$0**	**$97,727**	**$190,167**	**$249,949**	**$127,843**	**$9,177**	**$78,959**	**$38,348**	**$12,260**	**$8,277**
Expenses															
Personnel FORMULA	$485,500	$14,752	$35,903	$3,000	$0	$0	$53,650	$117,000	$155,450	$28,900	$8,500	$48,850	$25,950	$6,700	$8,900
Overtime	$3,700						$0			$2,000	$700	$500	$500		
FICA & Medicare	$37,906	$1,126	$2,746	$230	$0	$0	$4,104	$8,951	$11,892	$2,211	$421	$3,737	$1,932	$513	$425
IMRF	$45,239	$1,347	$3,278	$274	$0	$0	$4,408	$10,682	$14,133	$2,628	$502	$4,460	$2,187	$612	$507
Unemployment Insurance	$9,630	$295	$718	$60	$0	$0	$1,073	$2,442	$3,246	$1,578	$110	$977	$479	$134	$110
Employees Share Group Health Insurance	$72,230	$3,500	$7,750	$500	$0	$0	$11,750	$13,500	$22,000	$11,000	$900	$6,750	$3,250	$1,000	$500
Workers Compensation Ins	$9,910	$295	$718	$69	$0	$0	$1,078	$2,340	$3,109	$1,578	$110	$677	$479	$134	$110
Total Personnel	$674,415	$21,315	$51,110	$4,133	$0	$0	$76,048	$154,913	$209,753	$109,295	$7,843	$66,251	$32,677	$9,093	$7,143
Stationary and Printing	$4,439	$700	$1,000	$200			$1,900	$500	$1,000	$700	$100	$250	$100	$100	
Office Supplies	$4,800		$1,000	$200			$1,200	$1,000	$1,000	$500	$100	$500	$300	$100	$100
Operations Supplies	$5,643		$1,000	$643			$1,643	$1,000	$1,000	$3,000	$100	$500	$200	$100	$143
Postage	$4,600		$1,500	$100			$1,100	$1,000	$1,000	$700	$100	$200	$250	$100	$200
Medical Supplies	$3,200		$1,000	$100			$1,100	$0	$2,000	$100					
Books, Periodicals	$2,150		$200	$50			$250	$500	$500	$500	$0	$250	$100		$100
Total Supplies	$25,052	$700	$5,200	$1,293	$0	$0	$7,193	$4,000	$6,500	$5,500		$1,699	$950	$400	$500
Legal Fees	$2,500						$0	$2,500							
Occupancy	$47,685	$2,350	$5,315	$330	$0	$0	$7,355	$18,230	$14,520	$7,260	$330	$1,455	$2,145	$660	$330
Telecommunications	$578	$25	$62	$4	$0	$0	$94	$124	$176	$88	$4	$54	$28	$8	$4
Consulting Fees/Laboratory/medical exams	$14,000						$0	$4,000	$10,000						
Automobile Mileage	$21,100	$500	$500	$2,000			$3,000	$3,500	$1,900	$5,000	$1,000	$5,000	$2,500	$2,000	$100
Other Contractual Services	$2,700	$200	$400	$100			$700	$400	$500	$500		$200	$300	$100	$200
Business Meals Expense	$300						$0	$300							
Conference and Meetings	$6,600	$400	$600	$100			$1,100	$1,000	$1,500	$1,500		$1,000	$500		
Dues	$0						$0								
Patient Care and Client Assistance	$324	$324					$324								
Dual and Licenses	$3,000						$0	$3,000							
Conferences and Training	$0						$0								
Contingent Expenses	$2,000						$0	$2,000							
Miscellaneous Expense	$1,500						$0	$1,500							
Total Contractual	$102,287	$3,762	$6,977	$2,534	$0	$0	$12,973	$26,554	$28,196	$14,848	$1,334	$10,709	$4,771	$2,768	$634
Vehicle Purchase	$0						$0								
Medical Equipment	$1,613		$313				$313		$1,100						
Computer Purchase	$7,000		$300				$300	$2,000	$3,500	$1,200					
Furnishings and Office Equipment	$2,800		$400				$400	$300	$800	$500		$300			
Total Equipment	$13,313	$0	$1,013	$0	$0	$0	$1,013	$2,800	$5,500	$1,700		$300	$0	$0	$0
DIRECT EXPENSES	$812,707	$25,777	$64,000	$7,950	$0	$0	$97,727	$190,167	$249,949	$127,843	$9,177	$78,959	$38,348	$12,260	$8,277

END NOTES

[i] Community Mental Health Center Manual for Board Development, Superintendent of Documents , U.S. Government Printing Office, Washington, D.C.
[ii] Illinois Compiled Statutes, Counties Code 55 ILCS
[iii] Underscore emphasis added for ease of review.
[iv] Institute on Medicine three core functions of public health and U.S. Centers for Disease Control and Prevention Public Health Performance Standards
[v] Illinois Administrative Code TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER h: LOCAL HEALTH DEPARTMENTS PART 600 CERTIFIED LOCAL HEALTH DEPARTMENT CODE
SECTION 600.100
[vi] Funds have been subject to 3% contract clauses and possible mid-year reductions based upon state budget restrictions.
[vii] Reference Attachment A. Certification Rules
[viii] Reference Attachment B Local Health Protection Grant Rules
[ix] St. Louis Regional Chamber & Growth Association (RCGA) Regional and County Profiles
[x] U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, 2000 Census of Population and Housing, Consolidated Federal Funds Report, Census of Governments
Last Revised: Friday, 12-Jan-2007
[xi] Interview with James Stone, Public Health Administrator, Sangamon County - March 30, 2010.
[xii] 70 ILCS 905/11(from Ch. 111 1/2, par. 11)
[xiii] 55 ILCS 5/5-25009
[xiv] Champaign Urbana Public Health District revenue and expense report by cost center July 2008-June 2009 and budget submission information for the 2010 Champaign County Health Department contract.
[xv] For the FY10 Proposed contract the BOH's share of the larger cost center was $113,655.
[xvi] An administrator serving in this capacity must meet the statutory requirements to oversee a public health department as promulgated by the Illinois Department of Public Health.
[xvii] Kevin Barrett, Dr. P.H. of the Illinois Public Health Institute, Understanding the Present and Planning for the Future: An Analysis of Current Structures, Functions, Dynamics and Options, March 10, 2005.
[xviii] Kevin Barrett, Dr. P.H. of the Illinois Public Health Institute, Understanding the Present and Planning for the Future: An Analysis of Current Structures, Functions, Dynamics and Options, March 10, 2005, Page 9
[xix] Attachment C., Issue points for Champaign County Board of Health members, Composite
[xx] Issue points for Champaign County Board of Health members, Composite, question 1.
[xxi] Issue points for Champaign County Board of Health members, Composite, question 4.
[xxii] Issue points for Champaign County Board of Health members, Composite, question 2.
[xxiii] Agreement between the Champaign Urbana Health District and Champaign County Board of Health and Champaign County.
[xxiv] Issue points for Champaign County Board of Health members, Composite, question 3

CHAMPAIGN COUNTY BOARD OF HEALTH

Brookens Administrative Center
1776 E. Washington
Urbana, IL 61802

Phone: (217) 384-3772
Fax: (217) 384-3896

Champaign County Board of Health

Tuesday, May 25, 2010
6:00 p.m.
Lyle Shields Meeting Room
Brookens Administrative Center, 1776 E. Washington
Urbana, Illinois

ADDENDUM

CHAMPAIGN COUNTY ADMINISTRATIVE SERVICES

1776 EAST WASHINGTON
URBANA, IL 61802
(217) 384-3776
(217) 384-3765 – PHYSICAL PLANT
(217) 384-3896 – FAX
(217) 384-3864 – TDD
Website: www.co.champaign.il.us

ADMINISTRATIVE SUPPORT
DATA PROCESSING
MICROGRAPHICS
PURCHASING
PHYSICAL PLANT
SALARY ADMINISTRATION

MEMORANDUM

TO: **Carol Elliott, Chair – C-U Public Health District**
Julian Rappaport, Chair – County Board of Health
Brendan McGinty, Chair – Finance Committee of the County Board
Julie Pryde, Public Health Administrator - CUPHD

FROM: **Deb Busey, County Administrator**

DATE: **May 21, 2010**

RE: **DISTRIBUTION OF PUBIC HEALTH LEVY for FY2010**

As you are all aware, the Public Health Levy collected by the County each year is to be distributed to two entities – the C-U Public Health District and the County Board of Health. The determination of the amount of the levy to be received by each entity is dependent on the split of the EAV between the incorporated areas of the Cities of Champaign and Urbana, and the EAV of all areas outside Champaign-Urbana.

At the time the County prepared the FY2010 budget, it was anticipated that the total levy would be $900,231 and that the split of the EAV for the property taxes collected for 2009 would be 58.07% within the Champaign-Urbana Public Health District and 41.88% in the areas of the County outside of the CUPHD. The County's budget for Public Health was projected according to that breakdown. It has now been confirmed by the County Clerk, that the certified levy is $898,464.06 and that the actual distribution of the EAV for the 2009 property taxes (collected in 2010) is 57.77% within the Champaign-Urbana Public Health District and 42.23% in the areas of the County outside the CUPHD.

This change in the breakdown will create a change in revenue distribution in FY2010 in the County Board of Health budget. The revenue from the property tax collected on behalf of C-U Public Health District will be decreased from $523,034 to $519,100.46. The revenue from the property tax collected on behalf of the County Board of Health will be increased from $377,197 to $379,463.60.

	FY2010 Original Budget	Original % of Levy Breakdown	Certified FY2010 Budget	Certified % of Levy Breakdown	Increase/ Decrease after Certification
TOTAL LEVY	$900,631.00		$898,564.06		-$2,066.94
County Board of Health	$377,197.00	41.88%	$379,463.60	42.23%	$2,266.60
CUPHD	$523,034.00	58.07%	$519,100.46	57.77%	-$3,933.54

These changes do not require any change to the FY2010 County Board of Health Budget, unless the Board of Health requests additional changes based on this information. I am writing simply to inform all interested parties of the status of the distribution of the Public Health Levy that will be made over the next several months.

If you have any questions or concerns regarding this matter, please feel free to contact me. Thank you for your consideration.

xc: Dan Welch, Treasurer
Tony Fabri, Auditor
Carol Wadleigh, Chief Deputy Auditor