Champaign County Board of Health

Understanding the Present and Planning for the Future: An Analysis of Current Structures, Functions, Dynamics and Options

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I. Introduction

This report details findings and recommendations for consideration by the Champaign County Board of Health (CCBOH) based upon an analysis of historical events and current dynamics associated with a contract with the Champaign-Urbana Public Health District (CUPHD). The current contract authorizes the provision of public health services by CUPHD to Champaign County residents outside the jurisdiction of Champaign-Urbana. The contract covers both services mandated by the Illinois Department of Public Health and additional services determined to be regional priorities for Champaign County residents.

The primary purpose of the analysis is to provide objective data and information that will assist the CCBOH in determining the best path forward based upon an assessment of four options, including:

- Form an independent public health department
- Merge with a public health department from another county
- Contract for selected services with other local providers
- Resolve contract and associated issues with CUPHD

In the analysis of historical dynamics and circumstances contributing to the current situation, a series of recommendations will be offered to assist with a process of strategic planning by the CCBOH. Particular attention is given to the clarification of board roles and responsibilities, and the development of protocols that increase accountability and facilitate informed and efficient decision-making.

A. Summary – Formation of CCBOH and CUPHD Contract

The Champaign County Health Department was established through a referendum in 1996. During the subsequent two years, a series of discussions between the Champaign County Board (CCB) and a variety of citizen and representative groups to determine how best to implement the elements of the referendum. The CCBOH was established as a formal governance body to oversee the delivery of public health services to Champaign County residents outside the jurisdiction of Champaign-Urbana in 1998.

The CCBOH entered into the first contract with CUPHD to provide services to Champaign County residents outside the Champaign-Urbana public health district in November 1998. The contract period was 5.5 years, expiring in April of 2003. The current contract was negotiated in late 2002 and early 2003. It was initiated in May of 2003, and officially expires in November 2008.

In the course of developing the current contract, a number of disagreements arose between the CUPHD Board and the CCBOH regarding the relative decision-making power and role of the CCBOH in shaping the services provided by the CUPHD in the contract. The inability by both parties to resolve these issues resulted in a temporary interruption of services to County residents outside the jurisdiction of Champaign-Urbana in the spring of 2003. During this period, a number of staff members at the CUPHD responsible for providing these services were laid off.

The CCBOH accepted the terms of the contract shortly after the interruption, and most of the individuals were re-hired by the CUPHD and services were restored. In the period since this restoration, however, the CCBOH has raised a number of concerns regarding the design, targeting, and type of services provided by the CUPHD to County residents. In the process, the working relationship between the CCBOH and the CUPHD Administrator has deteriorated further; disagreements have also arisen between CCBOH members.

Given these dynamics, the CCBOH initiated a strategic planning process in April 2004, and began exploring alternatives to contracting with the CUPHD. A number of sessions were held in 2004, with the ultimate decision to commission an analysis of options by an external consultant. This report is the final product of that analysis.

B. Approach to Analysis

This analysis includes an objective assessment of recent events and current dynamics, which provided a context for the analysis of the four options and associated projections. A central goal is to move local parties from a recent focus on problem identification to an emphasis on problem solving. As such, this report moves beyond an analysis of the four options to provide a set of recommendations and practical strategies to increase accountability, strengthen public health functions, and build a common vision for the future.

The analysis and recommendations are informed by an understanding of public health as a local/regional system, rather than a public sector agency acting on its own. As such, an important function of the local public health agency is to leverage its resources and expertise to mobilize the full spectrum of public and private sector agencies, community groups, and citizens to improve health status and quality of life in local communities. In this sense, public health should not viewed simply as a network of safety net services for the poor and disadvantaged, but a system of surveillance, facilitation, coordination, and policy development for the whole population. This understanding of public health draws from primary research by the author into innovations by local public health agencies in communities across the country, as well as a review of secondary data.

II. Methods

The analysis and findings of this report are based upon the collection of information from five sources, including:

- Written information provided by CCBOH members
- Telephone and in-person interviews
- Written information provided by other individuals in Champaign County
- On-line information
- Review of literature

Written information provided by CCBOH members

The President and Secretary of the CCBOH provided a packet of information at the outset of the inquiry in response to a request of the consultant. Materials included CCBOH meeting minutes for 2003 and 2004, the CCBOH-CUPHD contract, the CCHD Ordinance, CCBOH materials generated for strategic planning purposes, written communications between the CCBOH and other entities, media articles,

Telephone and in-person interviews

A total of 21 interviews were conducted with CCBOH members, former and current CUPHD staff and board members, and outside stakeholders identified by CCBOH and CUPHD board members. Interviews were semi-structured, and intended to solicit personal perspectives and flesh out key issues identified in the review of written information. An additional objective was to explore options for moving forward and to solicit views on strengths and weakness of alternatives discussed. Most interviews were conducted by phone, and all phone interviews were with individuals.

Additional interviews were conducted during the initial site visit on January 22nd – 26th; most of those were individual interviews, and two were with multiple individuals. In some cases, multiple interviews were conducted with the same individual, in order to follow up to clarify information acquired from other sources.

Written information provided by other individuals

In the course of conducting the interviews, a number of resources were identified by interviewees as useful in clarifying issues to be addressed by the CCBOH. Examples include, but are not limited to the Memorandum of Understanding between the Champaign County Developmental Disabilities Board and the Champaign County Mental Health Board and supporting materials.

On-Line information

Materials provided by CCBOH members and other individuals were supplemented by on-line searches to acquire information from CUPHD, IDPH, and other Illinois government websites.

Review of Literature

A number of publications are cited in the report as resources in the identification of innovations and for future public health planning in Champaign County. One specific example is the 1988 Institute of Medicine report entitled "The Future of Public Health."

III. Findings

A. Review of Contract Options

The following is a summary of key considerations and implications associated with each of the four options under consideration by the CCBOH. Specific recommendations associated with these options are provided in sections IV and V, based in part upon findings associated with the governance and operations of the CCBOH, the CUPHD board and staff, and community dynamics that are provided in other parts of section III.

Form an independent public health department

A key advantage of forming an independent public health department to serve residents of Champaign County outside the Champaign-Urbana district is the opportunity to design a spectrum of services and activities that are tailored to the specific needs and interests of these populations. Designing a system of services and activities that make optimal use of rural and village community assets could yield substantial benefits to local residents and elevate the profile of the Champaign County Health Department as a highly innovative government entity in the state of Illinois. In order to realize this vision, however, the CCBOH would need to move well beyond the current focus on safety net services, and examine options discussed in section V of this report.

In addition, the CCBOH would be in a position to establish an infrastructure of governance, management, and operations that includes clear mechanisms for accountability, encourages innovation, and makes optimal use of available resources drawn from tax revenues, state funds, and grant funded initiatives. These mechanisms are currently lacking, both in terms of the ability of the CCBOH to influence the design, targeting, and configuration of current services through the contract with CUPHD, as well as an ability to guide the structure and function of agency operations.

One key question is whether the current volume of revenues secured by the CCBOH are sufficient to operate an independent public health department. A review of Illinois counties with similar budgets suggests that this is possible, as illustrated in Table 1.[1]

Table 1 – Similar Sized Public Health Departments

Local PH Agency (Region)	Annual Budget	Population	FT Staff	PT Staff
Boone (Rockford)	$910,000	41,000	15	4
Bureau-Putnam (Peoria)	$990,000	42,000	23	2
Coles (Champaign)	$1,076,000	52,500	27	2
Effingham	$1,135,000	34,200	25	8
Fayette (Marion)	$1,480,000	21,802	15	29
Greene (Edwardsville)	$1,362,000	14,761	27	7
Hancock (Peoria)	$1,144,000	20,121	12	9
Jersey (Edwardsville)	$1,321,000	21,668	21	15
Pike (Edwardsville)	$1,364,000	17,384	25	10

[1] **Local Health Department Personnel Compensation Survey Report 2001**, Illinois Department of Public Health, State/Local Liaison Unit.

Further inquiry would be needed, however, to determine the relative effectiveness and scope of services provided by these local public health departments, as well as their current capacity to carry out core public health functions. Such evaluation would also need to take into consideration local dynamics, the potential contributions of private sector and other public sector agencies, demographics, and unique needs of local populations.

An analysis of staffing configurations and compensation of 91 of Illinois' 94 local public health agencies[2] also offers some insights into what kind of infrastructure and revenues would likely be needed to establish an effective agency. Thirty of the 91 departments (33%) serve populations of less than 25,000.

All 91 departments have a Public Health Administrator; 11 of the 91 PH Administrators have an M.P.H. (12%), 29 have an M.S. (32%), and 27 have a B.S. (30%). Forty-two of the 91 PH Administrators (46%) had a public health concentration in their training. Thirty of the 91 (33%) have less than five years experience in their position. Among PH Administrators with less than 5 years experience, the lowest starting salary is $24.70/hr., and the highest is $35.35/hr.

Forty-two of the 91 departments (46%) have a Business Manager, with starting salaries ranging from $8.48/hr. - $20.30/hr. in the 11 departments serving populations of less than 25,000 that reported employing persons in this position. Sixty-six of the 91 departments (73%) have a Director of Environmental Health, with starting salaries ranging from $9.55/hr. - $24.00/hr in the 18 departments serving populations of less than 25,000 that reported employing persons in this position. Table 2 provides a summary of these and other key staff positions and associated salary ranges.

Table 2 – Key Staff and Compensation

Position	PHDs serving <25,000 with this position/total	Lowest Starting Salary / Hr	Highest Starting Salary / Hr
Public Health Administrator	30/30	$24.70 (< 5yrs exp.)	$35.35 (< 5 yrs exp.)
Business Manager	11/30	$8.48	$20.30
Environmental Health Director	18/30	$9.55	$24.00
Public Health Nurse	21/30	$11.45	$23.92
Health Educator	20/30	$8.00	$21.36
Home Health Aide	15/30	$5.25	$12.49
Administrative Assistant	10/30	$7.00	$17.00

In general, data and experience in Illinois to date suggests that it would be possible to establish a new local public health department in Champaign County that serves residents outside of Champaign-Urbana.

There are a number of potential drawbacks, however, in the establishment of a second local public health department within Champaign County. First and perhaps most

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[2] See footnote #1.

obviously, the establishment of a parallel department within the same county will result in reduced economies of scale, both in the delivery of categorical services and in the overall management of departmental functions. One of the advantages cited by the CUPHD Administrator in the implementation of the contract with the CCBOH is that services provided to county residents are assessed as marginal costs; in practical terms, the County is only charged for expenses beyond those already assumed by the CUPHD. While the benefits/costs savings for the County have not been calculated to date, one might assume that some savings are accrued.

Regardless of the additional savings and related benefits that that can be clearly documented in the operation of CUPHD as a single entity serving Champaign County, the termination of this agreement would raise these issues in the public arena. In an environment where there is already some sensitivity about the collection of tax revenues, people may legitimately question whether the establishment of parallel departments is in the public interest. If such a path is pursued, it will be important to demonstrate how the new department can go beyond existing functions, volume and scope of services with the same budgetary allocation.

It must also be considered that the establishment of a parallel public health department may yield competitive dynamics in both the delivery of existing categorical services and in efforts to secure outside funding. Possible scenarios include, but are not limited to duplication of services, public confusion about qualification and sites for service delivery, and loss of external funding by one or both communities (some funders may view a lack of coordination across agencies as a negative factor). One interviewee cited legal conflicts that have emerged between the two local public health agencies in Springfield that are an outgrowth of these kinds of competitive dynamics.

Finally, it should be considered that the establishment of a new local public health department would require a substantial investment of time and energy by the CCBOH, well beyond commitments to date. It is likely that some services may be lost in the near term, as the CUPHD begins to scale back operations and staffing in preparation for termination of the contract.

Merge with a public health department from another county

Merging with another local public health department from a nearby county offers a number of potential advantages, not least of which would be the preservation of economies of scale for services and management functions. In addition, the CCBOH and their partner agency may benefit from shared learning of different experiences.

A further benefit may be the development of a contractual relationship with a non-Coleman Act[3] entity with a demonstrated capacity to provide informed leadership and ensure accountability among agency staff members. Under these circumstances, many of

[3] The CUPHD was established in 1937 under specifications authorized by the Coleman Act, most relevant of which is the formation of a three-member governing body comprised of elected officials, none of which are required to have medical or public health expertise.

the difficulties that have emerged between the CCBOH and the CUPHD may have been avoided. It is likely that a more equitable contract for services could be negotiated with a fully engaged governing body.

At the same time, the physical distance between the residents to be served by the other public health department may present significant logistical challenges. It is possible that cost advantages associated with economies of scale may be negated by increased transportation costs. While some interviewees identified possible candidates[4] for such a partnership, suggestions were made with clear acknowledgment of numerous practical obstacles, beyond the immediate logistical challenges.

In addition to practical challenges, it is unclear whether a likely candidate in a nearby county would share the same service priorities. High priorities in one county may not be in another, given variations in demographics, sources of revenue, political dynamics, and population distribution, among other factors. Barring good fortune and close proximity in the establishment of a partnership with another county's public health department, this may be the most potentially challenging of the four options under consideration.

Contract for selected services with other local providers

This option has the potential advantage of enabling the CCBOH to retain a contractual relationship with the CUPHD for some services for which both entities may derive advantages from consolidated staffing and delivery. It also has the benefit of supporting private sector innovation and making optimal use of local community assets.[5] Ideally, it would be beneficial to explore ways for both the CCBOH and the CUPHD to contract out with private sector agencies for the delivery of common services, if it can be determined that to do so would yield increased quality and effectiveness.

The current contract between the CCBOH and the Central Illinois Dental Education and Services (CIDES) is an example of selected contracting that appears to have resulted in an increased volume and scope of services available to local residents. More data is needed to determine the net benefits of this shift from public sector service delivery to private sector funding and public sector oversight. If it can be verified that this shift has produced net benefits, similar steps should be considered for dental services that are currently organized through the CUPHD.

In the absence of shared private sector contracting by the CCBOH and the CUPHD for common services (and consolidation and coordination of other services for public sector

[4] McClaine County was cited by one interviewee as the best option, but distance issues would make it problematic; Vermillion County was cited as having excellent leadership, but there are other considerable obstacles.

[5] "Community assets" is a term introduced by John McKnight at Northwestern University, and refers to a full spectrum of local community-based organizations, associations, coalitions, informal groups, individual leaders, and infrastructure that can be mobilized to help achieve health-related goals and objectives. The core assumption of the assets model as introduced by McKnight is that an over-emphasis on the delivery of high cost human services by professionals is a less than optimal use of scarce resources, and undermines the problem-solving capacity of communities.

delivery), the benefits of economies of scale are lost. Moreover, as demonstrated by the recent difficulties experienced by the CUPHD in the delivery of dental services, the viability of one or both parallel services may be at risk. As suggested with other options, the failure to agree upon a shared action could be viewed as a violation of the public trust in the sense that the parties involved have made decisions that result in a less than optimal use of public revenues.

Resolve contract and associated issues with CUPHD

This represents the best option in terms of preserving economies of scale and reinforcing the public trust in the commitment of parties involved to make optimal use of tax revenues. It also has the benefit of keeping public health functions within the parameters of Champaign County, taking advantage of nearly 70 years of experience at the CUPHD and the opportunity to enhance the long-term viability of both entities.

As discussed in the remainder of this section of the report, there are numerous challenges that must be addressed in order to resolve current difficulties between the two entities and enhance public health services and associated functions in Champaign County. The challenges include near term issues associated with the CCBOH-CUPHD contract, accountability for services, and developing a common vision. There are also structural and statutory issues that must also be addressed in order to enhance the long-term effectiveness of public health functions in Champaign County. By taking definitive steps to addressing these challenges, the parties involved can gain the satisfaction of acting in the best interests of the residents of Champaign County. Sections IV and V will outline those steps for consideration by the CCBOH and the CUPHD.

B. Dynamics with CUPHD Board

Findings in this section focus on the language of the current CCBOH – CUPHD contract, and an assessment of the CUPHD board structure and function.

Current CCBOH – CUPHD contract

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."

In practical terms, this language suggests that the CUPHD can determine the scope, site, targeting, and design of services delivered to County residents, and is not obligated to seek input from the CCBOH. In this situation, the CUPHD Administrator may choose to seek input from the CCBOH, but is under no obligation to comply with suggestions that may be offered.

The lack of oversight responsibilities for the CCBOH is further underlined in item #14 of the contract, which lays out a series of decision-making parameters, including, but not limited to the following:

> "a. The Public Health District has complete control over its internal operations."

and

> "d. It is the responsibility of the Public Health District and not of the County or its Board of Health to require the said employees providing services under this agreement to maintain any required qualifications."

While the governing body of a local public health department may not be involved in individual personnel and staffing issues, they typically have a substantial role in organizational strategic planning and proposed changes in internal structures and functions. This language effectively excludes the CCBOH from any involvement in the CUPHD, despite having a substantial role and stake in how the agency organizes itself to make optimal use of resources provided by the CCBOH.

On a related note, item #13 of the contract identifies the executive officer of the CCBOH and the County Health Department, indicating that

> "The Champaign County Board of Health is required to appoint a medical health officer as the executive officer or to appoint a public health administrator for the County Health Department. The public health administrator for the Public Health District shall function as such public health administrator for the County Health Department."

On one hand, this language sets up the CUPHD Administrator as the executive officer of both the County Health Department and the CUPHD. Yet the contract is framed in a way that treats the CCBOH as an external entity with limited decision-making authority, and ensures that the Administrator is only accountable to the CUPHD. The Administrator is placed in an awkward situation where he/she is supposed to serve and report to two boards, but only one has the functional authority to hold him/her accountable for his/her performance. This disconnect is evidenced by the Administrator in conversations with CCBOH members when he refers to the CUPHD governing body as "my board."

The contract is also problematic in terms of the omission of important language. For example, it does not address the need and manner in which administrative support will be provided to the CCBOH by the CUPHD. As a contrast, a recently executed Memorandum of Understanding between the Champaign County Mental Health Board and the Champaign County Board for the Care and Treatment of Persons with a Developmental Disability clearly addresses the shared responsibilities for administrative

costs and support.[6] The MOU also directly addresses the issue of accountability of the Administrator, with language indicating, "The Developmental Disabilities Board shall participate and provide input into the annual evaluation of the executive director."[7]

The MOU reinforces the concept of shared accountability and coordination between the Mental Health Board and the Developmental Disabilities Board by requiring quarterly meetings between the presidents of the two boards and the executive director to review the status in the provision of administrative services.[8]

Finally, the current contract between the CCBOH and the CUPHD does not address issues associated with legal liability associated with the delivery of services by CUPHD staff. While common knowledge would lead to the assumption that such responsibilities are borne by the CUPHD, the lack of clarity could produce problems in the event of a future accident by a CUPHD employee.

Interviews and written materials provided by local parties clearly indicate that the current language is at the core of disagreements between the CCBOH and the CUPHD board in the negotiation of the contract. Moreover, the consistent view of all interviewees who were involved in the process is that the most significant problem in efforts to resolve this inequity was the confrontational style of the attorney representing the CUPHD board. Accounts varied to some degree, but most interviewees perceived that the CUPHD board deferred to the attorney, rather than taking an active role to seek a resolution. At least one interviewee indicated that CUPHD board members deferred to the attorney in part because they did not trust or want to deal with the CCBOH. Regardless of the motivations of the CUPHD board, it appears that their attorney stepped beyond his role of providing legal analysis to assume a de-facto policy role in the contractual negotiations.

The decision by the CUPHD board to allow the contract with the County to expire, interrupt services, and temporarily lay off employees who provided those services clearly indicates a lack of understanding and/or sensitivity to the inequities of the contract and associated public trust implications.

In general, the terms of the second contract and the associated negotiations played a substantial role in contributing to the deterioration of the working relationship between the CCBOH, the CUPHD Board, and the CUPHD Administrator.

CUPHD Board Structure and Function

As referenced earlier in this report, the CUPHD was established under the auspices of the Coleman Act in 1937, which authorized a three-member governing board, which in this case includes the Chair of the County Board and the two Township Supervisors from

[6] Item 2 of the MOU indicates that the Mental Health board and the Developmental Disabilities Board shall proportionally share all costs related to staff and administrative support necessary to implement the directives of the two boards. Item 3 of the MOU indicates that the "Mental Health Board staff shall provide appropriate administrative services as directed by the Developmental Disabilities Board."
[7] Item 4 of the MOU.
[8] Item 5 of the MOU.

Champaign and Urbana. While there are undoubtedly a range of meritorious qualities held by these three individuals, a three member board such as this does not possess the breadth of expertise and experience to effectively provide oversight for a 21st century public health agency.

At a minimum, current state regulations[9] require an eight-member board, of which "at least two members 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 addition, a responsible jurisdiction would seek members with expertise in specific areas such as epidemiology, health education, and public health nursing, as well as lay individuals with demonstrated knowledge of populations and community-based organizations within the service area of the public health agency.

Interviews with CCBOH members and current and former CUPHD administrators clearly suggest that the current CUPHD governing structure is not capable of providing the informed and ongoing oversight that is needed by the people of Champaign County. Aside from the issue of expertise and experience, interviewees indicated that Township Supervisors are often unaware of their responsibilities associated with the CUPHD until after their election, and once informed, are unable to devote the time needed to provide the most basic level of oversight.

In this context, it is difficult for the CUPHD board to provide little more than a legal umbrella for the CUPHD operations, relying upon the CUPHD Administrator to possess the discretion to ensure that all functions are being carried out in an optimal manner. In such a situation, the Administrator is not being provided with an informed review of proposed actions, and is subsequently more susceptible to failure and is vulnerable to criticism from outside observers. In short, the Administrator needs a board that will more equitably share the responsibility for decision-making.

One practical example of this phenomenon is the fact that the CUPHD Administrator has carried out what he referred to as a "total re-organization" of CUPHD management and operations over the last few years. Some aspects of this re-organization and its impact upon the delivery of services to County residents have been questioned by CCBOH members, despite the fact that the contract does not allow for input from the CCBOH. When questioned, the Administrator acknowledged that he had not presented a plan for this "total re-organization" to the CUPHD board. This plan should outline key goals and objectives, a conceptual framework, and underlying assumptions. In a normally functioning public health board, review and approval of such a plan would be essential; moreover, the Administrator would be held accountable for his/her relative achievement of identified objectives.

Another issue identified in dialogue between the CCBOH and the Administrator is the high level of turnover observed among CUPHD staff in recent years. This presents considerable challenges to maintaining optimal quality and continuity of services and core function activities. Despite the importance of this issue, there has been no request

[9] Illinois Counties Code (55 ILCS 5/5-25012).

by the CUPHD board to analyze and explore ways of addressing the causes and detrimental impacts of this problem.

In the most general sense, the current CUPHD governing structure is not conducive to planning and implementation that is informed by a detailed and comprehensive understanding of public health theory. The net result is that the CUPHD Administrator makes decisions with the tacit approval of the CUPHD Board, and without the level of inquiry and oversight that is needed to ensure optimal quality and continuity.

C. CCBOH Structure, Function, and Dynamics

The CCBOH is a nine-member body that complies with minimum current state requirements for composition. In addition, it is clear that considerable effort has been made to include members with a broad range of competencies.

That having been said, there has been insufficient attention to the development of a comprehensive understanding of their role as a governing body for a local public health agency. This shortcoming appears to be a problem both with the CCBOH and the CUPHD board. While there are presentations from time to time about the work of CUPHD staff on state/national public health initiatives such as APEX-PH,[10] IPLAN,[11] AND MAPP,[12] the role of the two governing boards in guiding and ensuring the effective implementation of these initiatives is unclear. The development and implementation of comprehensive community-based prevention strategies should be an important process that is overseen by both boards, but appears to be absent from the agenda and deliberations of the CCBOH.

Input from some interviewees from public sector agencies and community groups suggest that CUPHD leadership and staff tend to operate in an insular manner, focusing on internal strategies to deliver categorical services, and missing opportunities to make optimal use of existing community assets. To the degree that these charges are accurate, it is important to note that such inclinations are not uncommon among local public health agencies. That having been said, the Administrator has indicated the commitment of the CUPHD to implement the MAPP initiative. A central goal of MAPP is the broad engagement and mobilization of diverse community stakeholders in a process to improve community health. It is the responsibility of the Administrator to articulate what is being

[10] The Assessment Protocol for Excellence in Public Health is a national initiative that started in 1987 and focuses on strengthening the assessment capacity of local public health agencies and developing coordinated community health improvement plans. It is sponsored by the American Public Health Association, the Association of Schools of Public Health, the Association of State and Territorial Health Officers, the Centers for Disease Control and Prevention, and the National Association of City and County Health Officers.

[11] The Illinois Plan for Local Assessment of Needs is a statewide initiative that started in 1994 and is based upon the goals and objectives of APEXPH.

[12] Mobilizing for Action through Planning and Partnerships is a national initiative that began in 2000 that is sponsored by the National Association of City and County Health Officers and the Centers for Disease Control and Prevention.

done to advance this agenda, and the role of the CUPHD board and the CCBOH to hold the Administrator accountable for progress in the achievement of identified objectives.

Information acquired from written materials and interviewees suggests that a theory of action is needed for in the determination of what kinds of services are most appropriate. How does any particular service help the CUPHD fulfill its mission and vision? What are its specific contributions? What are alternatives? How can community stakeholders and private sector entities be engaged to advance goals and objectives? Addressing these kinds of questions is an important dimension of oversight that appears to be lacking in the deliberations of both the CCBOH and the CUPHD. For the CCBOH, it is likely that the constraints inherent in the language of the contract undermine the potential to even consider addressing these larger issues.

In rare cases where the Administrator has provided a means for the CCBOH to provide input related to the design and targeting of services provided under the contract, there has been insufficient attention to specific protocols that clarify what decisions will be made, the role of the CCBOH, and under what circumstances. The recent analysis of rural clinics is a case in point. Two CCBOH members were appointed to meet with CUPHD staff and help to determine whether some clinic sites might be closed, and where services may be expanded and/or consolidated. There was no advance dialogue, however, to establish a protocol to establish how decisions would be made. For example, would the two appointees be empowered to make decisions on behalf of the CCBOH, or would they collect appropriate information and bring it back to the CCBOH to make a formal decision as a full body?

Of equal importance, there was no in depth dialogue to clarify the objectives of the clinics, determine what criteria would be used to determine the relative effectiveness of clinics, identify possible reasons for suboptimal results to date, propose what may be done to increase their effectiveness (e.g., outreach, social marketing, partnerships with others in public and private sector), and whether there may be alternative ways to accomplish the same objectives. The net result is that decisions were made by CUPHD staff with input from the two CCBOH members, and there was no clear documentation of criteria and justification. Moreover, there appears to have been no advance public notification and/or dialogue that would have helped to further illuminate key issues.

On a related issue, CCBOH members have expressed concerns about the high level of turnover among CUPHD staff in recent years, as well as what appears to be a decision to defer the hiring of public health nurses in favor of clinical nurses with two year degrees. The CCBOH-CUPHD contract, however, clearly indicates that the CCBOH has no say in these issues, despite the fact that it has a direct impact upon the quality and volume of services provided under the contract. It appears that there has been no effort to date by the CUPHD board to address these issues. One example would be to request a report from the Administrator to document the reasons for resignations cited in exit interviews, comparable salaries for staff positions in other agencies, and potential resources for hiring of new staff. Analysis and remediation is clearly needed to address these issues.

Review of written materials, interviews, and direct observation suggests that monthly meetings of the CCBOH are not very productive or satisfying for board members or CUPHD staff. A substantial portion of time is devoted to review and questions about data reports and associated services provided under the contract with CUPHD. Both board members and the CUPHD Administrator have expressed frustration with the amount of time devoted to these issues. From the perspective of the board members, given their limited role in determining the design, targeting, and agency coordination to deliver these services, one of the only issues left to consider is whether the volume of services delivered is justified given the monthly charges assessed by the CUPHD. In many cases, it appears that the quality of the data provided by CUPHD staff is less than optimal, and discussion focuses on how and when these issues will be rectified. These and related issues then become the focus of subsequent meetings.

A number of CCBOH members and the Administrator also indicated that minutes taken for meetings are inaccurate reflections of the meeting proceedings, citing selectivity in documenting conversations, as well as the use of hyperbolic language. Review of the minutes leads the reader to assume that the bulk of conversations are being captured, but not as comprehensively as would be the case if they were transcripts. Board members also noted that minutes are not circulated in a timely enough manner to allow for detailed review in advance of monthly meetings, and they are reluctant to take up substantial amounts of meeting time to challenge their accuracy. Many interviewees cited this process as a substantial source of dissension among board members that has become increasingly personalized.

D. CCHD and CUPHD Identity

One of the key issues identified by interviewees and discussed at length in the January 25th CCBOH meeting is the public identity of the CCHD in general, and related to public notification of specific services delivered by CUPHD staff.

The stated view of the Administrator is a concern that public representation of both entities will confuse many, at the expense of both departments. He also indicated that most people don't care what agency is the sponsor of services they receive. In contrast, a number of CCBOH members indicated that they have heard directly from constituents who care very much about these issues. A key reason cited is validation that the tax revenues they provide are being used for a meaningful purpose. This may be of particular concern given historical challenges associated with establishing an assessment when the CCHD was established.

Some CCBOH members indicated that they have raised these issues for the last year and a half, and there has been reluctance by the Administrator and CUPHD staff to cooperate in a timely manner. This issue was discussed in the January 25th meeting as it relates to the clinic closures discussed in Section IIIC. CCBOH members expressed frustration that they had requested enhanced outreach and public communications over a year ago to increase the numbers of clinic participants. In their view, the closure of certain clinics

was premature, given the fact that the outreach and public communications requested by the board did not occur.

In the midst of this discussion, CCBOH members were made aware that a recent press release to announce dates for the delivery of services at remaining clinics did not reference the CCHD. This occurred despite the fact that individual members had worked directly with CUPHD staff to develop wording that would be acceptable. In response, the Administrator indicated that the wording of the press release has since been changed, but also indicated that he didn't think it made a difference. These exchanges clearly indicate a division on the issue of public identity. Perhaps more importantly, it highlights the fact that the Administrator does not appear to view himself as directly accountable to the CCBOH, even for services provided in their jurisdiction.

IV. Near Term Recommendations

This section includes near term recommendations for immediate consideration by the CCBOH and the CUPHD. Some recommendations were considered and approved during the February 26 retreat.

1. Selection of Contract Options

Given the range of available options and advantages and disadvantages of each, resolving the current issues with CUPHD is in the best interests of the people of Champaign County. Just as local public health agencies must strive to benefit all the people in their jurisdiction, the governing bodies of the agencies must seek solutions that represent the best interests of all constituents. In this case, local consolidation of functions represents the optimal fulfillment of the public trust obligations of these entities.

In order for this option to be feasible, however, a number of substantive changes are needed in the contractual and working relationships between the CCBOH and CUPHD board. These changes must reflect a more equitable sharing of oversight responsibilities for public health services and core functions, and for the individuals in the CUPHD leadership charged with implementing governing board decisions. The administrative leadership of the CUPHD is responsible both to implement the decisions of the two boards and to ensure that the boards are provided with the information necessary to make informed decisions. There cannot be effective governance without accountability, and there cannot be accountability without timely access to accurate information. Specific strategies to strengthen oversight responsibilities for both boards are offered in subsequent recommendations.

If this option were selected by the CCBOH, a reasonable step would be to appoint a working group of two representatives from each board to review and revise the current contract to reflect

- CCBOH oversight responsibility for services and core function activities to be carried out in CCHD service area.
- CCBOH input in annual evaluation of Executive Officer shared with CUPHD board.
- Build administrative support for CCBOH board functions into contract.
- Address CCBOH and County Board liability issues.

Attorneys for the two boards should play a role in reviewing revisions in the language and identifying potential legal concerns. They should not, however, step beyond their legal advisory role; policy decisions are to be made by board members entrusted by the public with policymaking responsibilities.

Finally, there must be serious consideration of a long-term strategy that will move towards the consolidation of governing functions between the CUPHD and the CCBOH. In the near term, appropriate steps should be taken to better inform and support the decision-making of existing CUPHD board members. Long-term options are addressed in Section V.

2. CCBOH Meeting Minutes and Administrative Support

Retreat participants considered and approved the recommendation to relieve the CCBOH Secretary of the responsibility of taking minutes at meetings, shift the responsibility to a CUPHD staff member to be appointed by the Administrator, and revise the format and process. In the future, the CUPHD staff member will limit documentation to brief summaries of the content areas being addressed, actions taken, persons responsible, and associated times for completion. Minutes are to be completed and disseminated at least one week in advance of CCBOH meetings.

3. CCBOH Meeting Agendas

Retreat participants considered and approved the recommendation to revise and clarify the process of setting CCBOH meeting agendas. In the future, the Secretary will draft the next meeting's agenda during the last five minutes of each CCBOH meeting. In consultation with the CCBOH President and the Attorney, the Secretary will consider and integrate additional agenda items proposed by CCBOH members and the Administrator up to 72 hours prior to the next meeting. At 72 hours prior to the next meeting, the Secretary will forward the final agenda to the Administrator for public posting.

4. CCBOH and CUPHD Public Identity

Retreat participants examined the issues of identity and representation of the two entities providing public health services to the residents of Champaign County. It was acknowledged that there are legitimate reasons to ensure that residents outside the CUPHD jurisdiction are aware that the services they receive are made possible through their support of the CCHD, and that such recognition is necessary unless and until there is a consolidation of the two entities.

It was noted that the CCBOH has appointed an individual to consult with the CUPHD board to determine how best to achieve this shared public identity and at the same time minimize confusion. It was also noted that prior obstacles to use of the CUPHD website to present this shared identity have been eliminated.

One suggestion put forward for future consideration was the formation of a council of rural agencies and village representatives. Such an entity could provide valuable input to the CCBOH and the CUPHD on how best to organize and deliver services, as well as how to make optimal use of local assets.

5. CCBOH data/information review, input, and Administrator revisions

Given concerns expressed about the amount of CCBOH meeting time devoted to the review and questions about data presented by the Administrator, establish a protocol for dissemination of data to CCBOH members via email at least two weeks prior to each monthly meeting. Questions from CCBOH members and responses from the Administrator via email will be completed 72 hours in advance of each meeting. Unresolved issues will be included as specific agenda items. Both the Administrator and individual CCBOH board members have expressed support for this type of protocol in discussions during the information collection process.

V. Planning for the Future

Resolutions of the immediate challenges associated with the contract and working relationships between the CCBOH and the CUPHD board and staff will open up new opportunities to build local capacity and critically review long-term options for the people of Champaign County. This section covers both of those issues.

A. 21st Century Public Health: Beyond Safety Net Services

These recommendations outline steps to be taken in order to strengthen the core functions of the CUPHD and the CCHD, and to take optimal advantage of emerging innovations in the field. A key consideration is how to elevate public health in Champaign County as a system of organizations, associations and individuals, rather than a single safety net agency. As stated in the landmark Institute of Medicine study entitled The Future of Public Health, "the identification of public health with care of the indigent in the minds of decision makers and the general public sometimes clouds the perception of the importance of public health to the entire population."[13] It is important for the CCBOH and the CUPHD to come together and dispel that perception in Champaign County.

1. CCBOH and CUPHD Board Development

At the completion of the contract review and revision process, plan a joint board retreat to address a range of issues, including, but not limited to the following:

- Vision of public health, guiding principles, and roles of the boards in overseeing and facilitating the achievement of that vision.
- Scope of competencies needed on the boards given the vision outlined.
- Assumptions, expectations, and mode of practice (ground rules for behavior)
- Protocols for decision making
- Long term plans (e.g., shared governance, or consolidation?)

It is likely that a single daylong retreat will be insufficient to effectively cover these and related issues in a meaningful manner. As suggested in the contract review process, the boards may want to appoint individual members and/or outside stakeholders to flesh out tools, protocols, and plans for subsequent review by the boards.

In general, time should be set aside on a regular basis to support board education about emerging issues in the public health and related topic areas.

2. Community Partnership Development

Specific measurable objectives should be established for the CUPHD that reflect a commitment to build stronger working relationships with the full spectrum of community

[13] Page 110, The Future of Public Health, Committee for the Study of the Future of Public Health, Division of Health Care Services, Institute of Medicine, National Academy Press, Washington, D.C., 1988.

stakeholders. Particular attention should be given to strategies that leverage CUPHD and CCHD resources to mobilize other private and public sector resources and achieve shared objectives. Allocation of staff resources for initiatives such as IPLAN, APEXPH, and MAPP should not be undertaken in the absence of specific objectives that establish a framework of accountability for results.

Two processes were identified in interviews that should be considered for CUPHD engagement. One is the local assessment referred to as the Continuum of Care Planning Process. One external interviewee indicated that CUPHD was invited to participate in this process, but never attended scheduled meetings. To the degree that such a process may be duplicative of a separate assessment conducted by CUPHD, it represents a missed opportunity and wasted resources. In any event, it represents the type of process and opportunity for partnership development that should involve the local public health agency. At least one objective should be to keep stakeholders at the table during the next phase of the process to identify ways of achieving mutual goals and objectives. As noted by the Administrator, the recent state statute requiring assessments by nonprofit hospitals represents an opportunity to work together more closely.

The second process is a public/private visioning process to be initiated by the County Planning Commission later this spring. The initial impetus for the visioning process was economic development, but it is a broadly framed process that includes an assessment of community quality of life. Local hospitals have already been approached to participate in the process; the Convener has indicated that the local public health agencies should participate, as well.

A number of interviewees identified the recent change in leadership at the University of Illinois as an opportunity to increase their engagement and support of local public health. There are individuals on the CCBOH with direct links to key UI decision-makers who could play a role in initiating a dialogue. Such a dialogue should occur on multiple levels, and should go beyond the medicine and nursing schools to include disciplines such as urban planning. There is increasing attention in the field to ways in which state-funded universities can and should provide support to local communities beyond the employment of local residents. The concept of community benefit and associated principles are viewed as increasingly relevant to all institutions that receive public funding.[14]

3. Contract out for specific categorical services

In the interest of building sustainability and making optimal use of increasingly scarce public resources, it may be appropriate to evaluate the potential contracting out of specific categorical services for delivery by private sector organizations. The decision by the CCBOH to contract out for dental services represents an example of that thinking. The first step in exploring this issue would be to conduct a comparative analysis of what resources were allocated and services were provided prior to and subsequent to the

[14] See chapter 6 in the recent Institute of Medicine report entitled "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," National Academies Press, 2004.

contracting process with CIDES. This is needed first to address differing perceptions among CCBOH members, and to determine if the subcontract should continue. If, in fact the contract represents a substantial enhancement in terms of returns on investment, CUPHD should seriously consider a similar contract with CIDES or another private sector agency.

This kind of arrangement in no way precludes the CCBOH or the CUPHD from fulfilling their three core functions of assessment, monitoring and assurance, and policy development. Contracting with private sector agencies to delivery categorical services has been increasingly encouraged throughout public health literature in recent years as a process of shifting the emphasis towards building capacity in the three core function areas.

B. Consolidation: Fulfilling the CC Public Trust

One long term option discussed at length at the February 26 retreat is the potential consolidation of the CCBOH and the CUPHD board to establish a single governing structure over an agency that serves all the people of Champaign County. The current parallel governing structures, one with limited membership, narrow composition and full oversight, and the other with diverse composition and limited oversight, is problematic at best. In the course of discussion at the retreat, the Administrator indicated that he had developed some strategies for consideration on how to work towards consolidation, but had been reluctant to share these ideas, given adversarial dynamics in the wake of the contract negotiations. These and other ideas should be given full consideration by both boards as part of the resolution process proposed in this report.

1. Analysis of Legal and Revenue Issues

A first step in this process would be to commission an analysis by the Administrator and the staff attorneys to identify legal and revenue issues to be addressed in order to achieve the desired level of consolidation. The analysis should identify specific steps to be taken, and implications of alternative options. Emphasis should be given to problem solving, rather than simply problem identification.

2. Interim Shared Governance

The recommendation for a board development process in V.A.1 should help to create an environment of shared understanding and interest between the two boards. If this were achieved, the follow up would be to take interim steps that move towards shared governance. A key consideration would be to support the work of the CUPHD board, and at the same time, facilitate alignment and coordination of actions by both bodies. One option would be to form an advisory board or subcommittee of the CUPHD board that includes selected CCBOH members and other representatives from the community. This body would devote the time to flesh out and frame issues that would be presented to the two boards, facilitating more comprehensive and in depth accountability on an agency-wide basis for achieving measurable results.

Note: The author would like to thank the members of the CCBOH, representatives of the CUPHD, and other individuals from Champaign County who took the time to meet, discuss relevant issues, offer perspectives, and share written information for the preparation of this report. Effort was made in the documentation process to balance the desire for confidentiality with the need to understand and articulate the different facets of an issue. In general, the focus of this report has been to offer solutions that are based upon an objective judgment of information that was provided. I offer my apologies for any misrepresentation of information in the report that may have come about as a result of gaps in information and/or my own misunderstanding.