The McLean County Board of Health
Wednesday, April 10, 2019, 5:30 p.m.
200 W. Front Street, Room 324, Bloomington, Illinois.

Minutes

1. **Call to Order:** 5:30 PM

2. **Roll Call**

**Members Present:** Ms. Judy Buchanan, Ms. Carla Pohl, Ms. Susan Schafer, Ms. Hannah Eisner, Ms. Rose Stadel, Dr. Scott Hume, Dr. Jim Swanson, Ms. Cory Tello, Mr. Robert Kohlhase, Ms. Sonja Reece

**Members Absent:** Dr. Alan Ginzburg

**Staff Present:** Ms. Camille Rodriguez, Mr. Tom Anderson, Ms. Kim Anderson, Ms. Cathy Dreyer, Ms. Amy Brooke, Ms. Lisa Slater, Ms. Tammy Brooks, Ms. Amy Hancock, Mr. Trevor Sierra

3. **Public Participation:** None

4. **Approve Minutes:** March 13, 2019 and April 2, 2019

Motion by Eisner/Hume to approve minutes from March 13, 2019.
Motion carried.

Members discussed revisions to the minutes of the April 2, 2019 special meeting with the Center for Human Services (CHS). These revisions included the addition of sections from a verbatim transcription:

- Confirmation in two places from Mr. Bob Keller that CHS would formally reply to the requests for information (end of page 8 and page 9).
- Inclusion of Judy Buchanan's statement that partnership and collaboration must be woven into seeking to meet the needs of this population.

Motion by Schafer/Kohlhase to approve the April 2, 2019 minutes as amended.
Motion carried.

**5. Committee Reports**

**A. Ad Hoc Funding Committee**

Judy Buchanan (JB) stated that this information will be covered in the report of the Health Department Administrator and under new business.

**B. Behavioral Health Coordinating Council**

Sonja Reece (SR) shared that the BHCC has not met since the last meeting BOH meeting.

**C. Mental Health Advisory Board**

Information related to the Mental Health Advisory committee is to be covered in the Health Department Administrator's Report.

**D. County Board**

Susan Schafer (SS) shared that a new administrator will be named at the full County Board meeting on April 23rd.

JB announced that the planning for the Annual Mental Health Forum has begun. A date has yet to be decided. The BOH will be kept abreast of the planning and date.

**6. Health Department Administrator's Report**

**A. Items to be presented for information:**

**1. Update on April 2, 2019 Board of Health Meeting**

CR gave a verbal up date to the special meeting with CHS on April 2nd. Ultimately, no new conclusions were made relative to the questions the Board had presented to CHS. However, there is now a public record of our concerns that have surfaced since the submission of that agency's calendar year 2018 application for 2019. There have been no subsequent meetings with CHS since April 2, 2019. It has been the desire of the BOH to ensure uninterrupted of services for individuals in Psychiatric or in Emergency Crisis Intervention during these discussions. The 2018 contract has been extended through the end of April. There are related action items on the agenda.

**2. Strategic Plan First Quarter Update**

CR shared that each week one of the Division leaders or program coordinators updates the senior leadership team on progress in their area of the strategic plan. She shared some of the recent updates.

The Community Mental Health Needs Assessment is going well. That team includes external parties. They have chosen priority areas and action teams are being assembled.

In addition, in the area of the Strategic Plan, Provide Public Health Leadership, all Division Directors and their supervisors are near completion of their own strategic maps.

Under Convene and Collaborate the HD worked well on the Opioid Initiatives and Partnerships. The HD is collaborating with the Sheriff's Department on a grant he obtained through the Illinois Criminal Justice Information Authority wherein he has now implemented a Heroin Action Response Team called HART. This is in addition to the SAFE Passages program that he, along with the HD, announced a few months ago. The work of the HD has been relative to communications. CR inserted that this is Lisa Slater's last meeting and she will be missed. She has made us look well over the years.

CR stated that the other part of the opioid initiative is that the sheriff has said that he is currently focusing on methamphetamines and ice and not as much on opioids. It isn't that opioids are not a problem, but they are not at the same level of crisis as much as methamphetamines in this jurisdiction.

The Behavioral Health Initiatives and Collaboration Project are very detailed. Amy Hancock is getting us ready to discuss some of the ad hoc funding work that has been done. We are still working on becoming a trauma informed agency. Ms. Hancock met with every employee and we have done a survey with the entire department relative to their feelings about next steps. This morning a State Department of Mental Health leader provided a Trauma Informed training for managers.

Under assuring strong workforce and business practices, Amy Brooke is leading an initiative on workforce development. One of the things being created is an onboarding manual to standardize the experience that new employees have. Secondly, an employee survey relative to the training needs that employees feel they need to do their job well has been conducted. Thirdly, Kim Anderson and Amy Brooke have taken up a new project that emerged upon the realization that everyone was doing performance evaluations in a different way. The process is being standardized. This includes looking at job descriptions. The last time a manual for the evaluation process was written was in 1996.

CR reported on changes to the dental clinic. Upon Tammy Brooks' realizations that patients were leaving frustrated because they were waiting past their appointment times, dental clinic hours and appointment lengths are being revised. It was discovered that 20 minutes was being allotted for a cleaning when it was regularly taking longer. Changes also include the addition of evening clinics.

**3.Environmental Health Division Update**

Tom Anderson (TA) provided an update. He described the role of serving clients in the restaurant industry as organized chaos. There is a lot that goes on behind the scenes. A manager comes in and sees something that needs to be done but there are a multitude of other things that take priority. His staff are the other pair of eyes that reminds the manager to do things.

TA reminded the BOH about the Weston Well. That has been completed. He said that he couldn't take full credit for it. Mr. Sierra was instrumental in taking care of the legal work. Building and Zoning did a wonderful job of contracting with a company to destroy the remainder of the house. It looks like a park in the middle of the county.

TA stated that his staff continue to work with a restaurant situation where the operator is trying to get open. He is having difficulties getting the inspections he needs from a municipality. He has another business he is trying to keep in operation yet close his former location for catering. However, he has moved his equipment over to his new site. We were able to look at the situation. The equipment is acceptable to our standards. All of his utilities are functional. It is just a little construction here and there. But it didn't prevent him from cooking all of his food and meeting his contractual obligations.

SS asked who comes first in that situation: Health Department or municipality?

TA explained that it sometimes happens simultaneously. Generally, a business operator will go to the City first and then work with the Clerk's office and Building Inspections Department. They will inform Environmental Health that they have a new proposal for a restaurant. Plans will be sent so that Environmental Health can review them.

SS asked if, once someone is ready to open, they had to first get the occupancy permit. Does that have to be done before they can be given a food permit?

TA stated that the occupancy permit does not impact the food permit. They can have a food permit, but if they don't have an occupancy clearance, they can't open. The City and the Town also give clearance on ventilation systems. That is more of a fire safety issue. If they have a natural gas fryer or range, they must have a mechanical hood over that. The municipality gives clearance on those.

SR thanked TA for working with this owner. She appreciated that he found a way to work with him, so they could meet their contracts.

TA stated that they recognize that operators/owners have a livelihood. They shouldn't be inconvenienced by any one entity.

RK expressed the same appreciation for the work the staff did with this owner.

**4. General Report and Other**

CR referred members to two documents in the packet. The first was a case study on pages 4-8. It provides a snapshot of a de-identified actual grantee. This shows the newly enhanced financial reporting system that grantees are being required to report on. This shows what they are using BOH dollar for. It isn't something that is normally provided to the BOH. In the past, this information was not asked for.

JB stated that on page 6 it refers to 7.4% for contractual services. Would that be 7.4% of the dollars that Health Department had provided?

Amy Hancock (AH) said that it is 7% of the funding toward that program. The contractual services entail annual audit, printing, occupancy, and postage.

JB clarified that the HD is paying a percentage of their audit.

AH stated that we are paying $2091 of their audit.

Hannah Eisner (HE) found the information helpful. It didn't seem skewed in anyway. She would have expected that most of the cost would be for personnel and this bears that out.

Cory Tello (CT) asked if this has been shared with the grantees.

AH affirmed that this information is shared during quarterly visits.

SS asked for an example of indirect costs.

AH stated that in this case study the indirect costs were personnel, fringe benefits, etc. They said that their indirect costs should be 15.2%. Indirect costs pay for administration, utilities, telephone, occupancy, etc.

SS stated that she thought our guidelines said it was10%.

AH stated that for the calendar year 2020, we are moving towards it being capped at 10%. That 10% would include all funding for indirect costs capped at 10%. If they receive 8% in indirect costs from a different funding source, the BOH wouldn't give them more than 2% towards indirect costs. That would be moving forward. She has begun the discussion with this agency of not having the BOH fund 15-17% of indirect costs.

SS asked what the current guidelines are.

CR stated that the 2019 guidelines says not to exceed 15%. These types of reports let the BOH look at these items and set expectations.

HE stated that it is not unusual to use a portion of a grant for indirect costs. There is a need to define with agencies the nature of indirect costs.

AH shared the intention of having Jackie Dietrich, part of Cathy Dreyer's team, doing financial audits. This will involve visiting different agencies and reviewing receipts and invoices to see where the money is going.

SR stated that the term "fringe benefits" is an old word. Benefits are an important part of compensation these days and are not fringe. Just call it benefits.

RK asked how going to 10% will change applications.

AH replied that it would change the process in general. Formerly, they would put their budget into the application. The BOH would say, "Sure, we'll give you $148,000." However, the discussion of how that was allocated never came back around. It was assumed the budget was approved because that amount was approved. Moving forward for 2020, this agency wants $148,000. Part of that application process will be the approval of that budget. The BOH might decide to only give $135,000 because they are asking for 20% of in indirect costs. It is important to have a conversation about the actual allocation.

SS stated that we want to buy services and not just fund indirect costs.

CR focused everyone on pages of 9-17. This provides data for making decisions on what our behavioral health funding priorities can be. This is very preliminary. AH went through some local and national data and is conducting a stakeholder survey with behavioral health providers, families, and participants to obtain localized data. It is a discussion piece. For example, young people may not be smoking but they are vaping. What does that have to do with behavioral health? It could have a lot to do with

behavioral health when if know that vaping and the initiation of those activities impacts brain development, coping skills, and decision making. Those are some of the things that could be relative to a funding priority. This is preliminary.

JB and CR discussed that recommendations of priorities for the behavioral health funding will be presented in June.

JB asked what the results of the Community Health Needs Assessment were.

CR stated that preliminarily behavioral health was on the list as well as access to care, and obesity and physical activity.

7. Old Business

**A. Items to be presented for Action:**

CR shared that these action items reflect our desire ensure uninterrupted services to individuals in the Psychiatry and Emergency Crisis Intervention. On Dec. 3, 3018, the Center for Human Services decided not to take any new patients. There have been multiple discussions requesting that they continue to take a small number of new patients. In the first two discussions, there was a flat-out no. In the last discussion, it does sound like they might be interested in taking a small number of new patients. That is not confirmed. Relative to what is on the action item, this is about having continued negotiations. The BOH members received templates of contracts in their packets. Those are only templates. There is opportunity to discuss what is inside those contracts and direct CR to negotiate a small number of new patients. A contract an opt out clause might be considered. Should the BOH continue conversations about plans B, D, or E relative to the longevity and sustainability of program like this and in the way, it is being implemented? There are so many complex parts to this. Discussions have not been fruitful in changing the thought pattern of how to do the program differently. CR is on record asking them if they have a different way they would like to approach this to be more sustainable. Managed care organizations collaborate all the time. You have a Federally Qualified Health Center in this community where people could obtain their primary care. Could CHS make a relationship with that entity, knowing that FQHCs can receive higher rates of return on their reimbursements? Those things have not happened in the conversations. There has been no indication that they will go down a new and innovative road. It is notable that existing services have not been interrupted. The BOH has been true to that point.

JB stated, with that in mind, month to month funding may not be the wisest way to go. Members are being asked to consider funding these programs through the end of the year. This will be an ongoing discussion at this table and in small focus groups. The BOH does not want to disrupt services. However, the BOH and CHS have

different expectations. Information has not been forth coming. JB suggested the possibility of a 90 day opt out clause. It is not so much that it may be used, but she wants to send a clear message that the BOH is continuing to look at this. As has been emphasized in information that has been released by the BOH, the cause of the BOH stepping back was when CHS said no to new patients. She stated, "We felt a responsibility that if they were going to leave them behind, we didn't want to leave them behind." At a minimum part of the negotiation is some new patient activity. What other specifications would members like to see?

HE stated that she went back to their application. In that application they represented that they would provide services for 800. Is that the number they applied for? The minutes from the meeting look like they are going to cut back to 500.

AH clarified that the 800-850 that they put in their application is services provided from monies across all the funders. CHS has confirmed is that we are paying for 250. The BOH provides 25% of the funding.

HE asked if the people being served were those without insurance.

AH and CR stated that it can't be.

CR stated that it is not codified in contract that way. Their expression is that they looked at what was in their application on Dec. 2nd and said that they had met the number they were obligated to meet. That was part of the basis for their decision. They felt they had met their contractual obligation. The learning curve for the BOH is deciding what the BOH pays for and how it is verified that what the BOH is paying for is coming to fruition through the action of the agency. If BOH funding pays for personnel because a lot of this is a Medicaid service, then how does the BOH show that the hours spent equals how many patients? How does the BOH equate a service from a payment of personnel? The challenge has been that it was written in that CHS would see around 750 patients total. It was never written in that at least 250 would be seen through BOH funding.

CT stated that they reported that BOH funding pays for services to the most severe. How do they quantify that? It sounded like they would not be cutting back on those clients because they are the most severe.

CR asserted the definition of what a patient is. In one of her conversations, it was suggested that an individual coming to pick up their medication only would be considered a new patient. She would assume that the BOH would want individuals to receive the compendium of services: medication, case management, and advocacy to community referrals. People have a choice. Maybe some only want the medication and don't want the other things. Are we going to count that as a patient and have they been counting those in that 850 number? How many are receiving the compendium of services versus picking up medication? The count and cost of

service would look different. CHS receives $700,000 - $800,000 in donated medications. That is also part of their business plan. Are they billing for those?

JB stated that it is incumbent on the BOH to drill down. On the other hand, there are no other viable options at this point. It may not be the best mix for putting forth a contract for the remainder of the year, but the BOH almost has to do it.

CT expressed concern that CHS was not able to answer where those currently being turned away are going. It is a huge concern.

SS suggested that, with Mr. Sierra's assistance, there might be some wording within the contract to penalize CHS for not providing to a certain number of clients each month. The contract needs some teeth to it. In both meetings they said they have places throughout Illinois to which to refer people. Can they provide numbers showing if these people are getting into the places they have been referred? Can that be tracked? The end goal is to get outcomes from them. Are people becoming more functional in society? Is Crisis really keeping people out of the Emergency Room?

JB stated that is really, within reason, what the discussion is. Some of those specifics need to be in there while recognizing that it may not be everything that is desired. There is next year.

SR asserted that they appear to feel that they are the sole provider for this kind of service. It is a needed service. Until there are options, it will be a challenge. Recognizing the shortage of psychiatrists, how are other communities addressing this issue? All those things play into our responsibility as a Health Department. Until we know where people can be referred, it is going to be challenging to set new expectations and limits. At the beginning of the discussion the number was 500 and now it is 250. At the end of conversation, she heard, "If we get the money, we can take the 800." The number keeps changing.

CR affirmed that the number does seem to keep changing. In another conversation, CR and Ms. Dreyer heard that even if they received the BOH funding and the $400,000 they still wouldn't take new patients. That is something that was documented and heard. The information has not been consistent.

JB stated that people have begun to explore what might become additional options in this county. A drop-in center and telepsychiatry are on the horizon. She asked Mr. Sierra if the BOH can get into this type of specificity in a contract.

Trevor Sierra (TS) stated that they absolutely could get into that level of specificity. The BOH can set the parameters for breach of contract. Payments can be scheduled on certain conditions.

HE asserted the need to come up with the right number for the balance of the year.

When this happened 5-6 years ago, the same questions were asked. It doesn't seem that it should be that hard to say on a per capita basis, this is what it costs. Being able to do that would allow for a formula. Realistically, the BOH has not acted because the BOH knows that people need services. This is a problem for the next funding cycle.

SS likened it to the nursing home. It isn't totally foreign to everyone. The questions Ms. Rodriguez is asking are not unreasonable.

JB clarified two options: 1) "Work with us on this, this, and this" 2)"We are done continuing to provide because you don't answer every question." The current decision is about continuing to provide funding for Crisis and Psychiatric Services knowing that there is a great deal of work to be done between now and contract negotiations for next year.

CR suggested that there is an opportunity. The Crisis contract has not been discussed thus far. It was brought to the forefront knowing that one does affect the other. There is an opportunity to hold them accountable relative to what they are doing with the individuals that need a psychiatric referral and have CHS track that. There are precise numbers they see each quarter in the emergency rooms of both hospitals. It is a lot of individuals. Information as to where they are referring people for psychiatric services could be required.

RK suggested it was a necessary meeting. All of this is part of the Board's maturation process of how grants will be tracked in the future. If the case study model was applied to CHS, how would that pie chart look? He referenced Ms. Tello's comment about seeing the most severely mentally ill. He stated that was in the context of identifying the cost relationship per patient. It indicated the high variability among patients and suggested that our dollars would take care of the worst situations. It isn't known if that is an accurate statement. As he tries to decipher this, there is an agreement for $715,000 this year. Good accountability of where that money is going is needed. There should be something of a dedicated account that says, "Health Department Grant." What is that money paying for? Is it serving the clientele that we expect? That is the amount of authority the BOH has. It doesn't go beyond that. Information is still missing. He believes there should be a move toward approving funding through the rest of the year so that the clients who need that service receive it. It will behoove the BOH to start introducing these topics to them. In the next funding cycle the BOH should have a much closer accounting of the funding and that it is serving the clients.

SS stated that she would like more accountability now. They have been stalling for years on any information anyone has asked of them. A foot needs to be put down.

JB asked, "If we put our foot down and go to the wall, what are we going to do if they don't deliver it. Are we going to say, 'No checks no forthcoming?'" Do we

want to feel responsible for leaving behind some of the most acutely ill?

RK stated that we can only change the future. One of his main concerns regards the reserves. How did those reserves grow? Out of our $715,000, if they have $50,000 left over, that $50,000 should still be within Health Department expectations and used for the clients. It shouldn't disappear into a general fund. It needs to be segregated.

Jim Swanson (JS) questioned if the BOH is being responsible if money is continued to be given without knowing where it is going.

JB suggested that there seems to be agreement that if upon giving the $715,000 that it must be tied much more strongly to documentation and accountability.

CT proposed that the BOH ask CHS to take on the proposed 5 new clients a month.

HE stated that the BOH has been funding them until now based on the 2018 number. The BOH needs to agree to fully fund them at the 2019 request level. There needs to be a mechanism for making payment.

CR clarified in the past the HD just sent the monthly checks. Currently, checks are not issued until financials are received. There are 1-2 agencies that have not received certain payments because they have not provided the necessary documentation. The HD is willing to augment this with in-person site visits. It would necessitate a personnel adjustment. With the CHS situation even higher than normal in person visits could be done. It would send a message. Ms. Hancock, Ms. Dreyer and CR have contacted other community mental health centers in the area. Those centers have said that if the HD was their funder, they would open their books to the HD. We would be able to look at their EHRs and billing practices. Confidentiality agreements can be put into place but show the BOH who you have been seeing so the BOH knows who is receiving the compendium and who is receiving medication. How does that work with how much time personnel are spending? Under the calendar year 2018 contracts, the dollars are supposed to be going to personnel.

CT asked if they currently have a leveled system where they rate clients in terms of the services they need.

CR replied that CHS simply states the highest level of need. We don't have verification of that.

RK asked how to distinguish between the reduction in United Way funding and reduction of clients and their assertion that they are maintaining the clients that are funded by the HD?

SR asserted that there are two areas where they are losing money: the State and

United Way. Their solution was to come to the HD and say, "Give us the $400,000 we aren't getting from the state. And, furthermore, instead of seeing 800 people, we will only see 500." Those two messages were unacceptable to the BOH. She doesn't expect the money from the State to come back and knows that the United Way money will not come back. Their challenge is to discern what they can do and will do and to do it smarter and better. In the April 2nd meeting, nothing was said about how they will manage it. Other providers of healthcare are re-examining how to do it and where. It's not business as usual. It shouldn't be business as usual for them either.

SS shared that when they lost the State grant money, the State provided new billing codes to recover some of that lost money. The BOH doesn't know if those codes are being utilized to assist in recovery of lost money.

HE pointed out that CHS received extra money from the Scott Commission this year. That should cover some of the shortfall.

RK pointed out that the BOH is only responsible for BOH money. The BOH wants accountability for that. They also talked about using reserves. That is a policy decision unless that money was accumulated from money intended for clients. Then, it should be drawn down to be used for clients. That is where the details are missing. He suggested that a conclusion on that might not be reached. He stated that the BOH should move forward with in a strong direction of how we are going to improve our relationship without hurting clients. One answer could be dialogue between Cathy Dreyer and their treasurer to show the trail of the BOH money.

Cathy Dreyer (CD) stated that it is something that has been worked on this year with funded agencies. It has been put into contracts that a budget must be provided. A budget template was created that is comparable to what the HD must do for its grantors. It lists out HD funds they would receive and how they would spend them. There is a section of non-HD funds and how those will be spent. The turned in budget must be approved. If any revisions need to be made throughout the year, they must present a revision request for approval. There are opportunities for line item transfers. If they transfer more than 10% or $1,000, approval must be sought. It is required that they keep a record of expenditures by category. This will allow staff to do an audit if it is requested by the Behavioral Health Program Manager and verify it back to the required monthly financial reports. The report lists approved budget, what was spent that month, and what was spent year to date, and the remaining balance. They must turn in the report every month. If they don't turn it in, a check will not be cut. These are then tied to quarterly reports.

CR stated that if the BOH asks for a monthly report like the quarterly report for the other agencies, it would be as if it were a corrective action plan. It may not be exactly what is desired, but it will be a step towards it.

RK asked if we have received adequate reports to make a payment.

CD stated that for CHS, the checks so far are not tied to those reports. They are still operating under the 2018 contract. These requirements are in the 2019 contract. They do this type of report for Embedded School programs. They are accustomed to doing this type of report but have not provided them for the psychiatric program.

HE clarified that we have some policies for all grantees in 2019. She is troubled by the idea of giving them the full grant amount when they say they will not be seeing the full number of people. She would like to see a mechanism of a certain amount of money for each of the additional 5 per month they see.

CR stated that the BOH might want to consider 5 per month or 35 by December 31st. There might be 7 one month and 3 the next. The BOH could look at a monthly payment plan at a baseline level. When and if they add new clients as we define a new client we could add additional funds.

SS pointed out that at the April 2nd meeting, CHS stated that the reserves have been built up over years. She stated that CHS is over 80% publicly funded between property tax dollars from us, when the State was giving them money, and Medicaid reimbursement – again tax dollars. There is an ethical obligation to spend that on the public – even if it is spending the reserves. Those reserves were derived from public funds. They are, basically, publicly funded. They should be spending it on the public rather than calling it a rainy-day fund.

SR reinforced what SS said. One of the things CHS was asked was, "How did you build reserves?" Their answer was that sometimes they received more than they spent. That was set aside. They were building their reserves on, for the most part, public money from the State and the County.

CR expressed that CHS made the statement that they serve psychiatric clients at $1500 a year and they do that well. She looked up the Medicaid rates, that have been enhanced lately, for behavioral health encounters, on average depending on geography, it is around $60 to $63 per encounter. That means that they see our patients only 20 times year. Does someone with severe and persistent mental illness only need to be seen 20 times a year? They are not giving the BOH all the information that is needed.

Discussion centered on the need to proceed with negotiations. Members felt that some stipulations should be attached.

TS stated that the BOH could grant open ended authority to Ms. Rodriguez to negotiate the contract or they could attach specifications that must be met to enter into the contract.

JS asked if an out clause would be included.

CR stated that she believed so and would discuss it with legal. She would look for the language that would leave the BOH the most options.

HE clarified that we have made payments for January, February, and March and will make an April payment based on 2018. How much has been paid out?

CD stated that for the Psychiatric program $108,580 and for Emergency Crisis Intervention Services $124,600 has been paid. For 2019 we levied $333,000 for Psychiatric and $382,000 for Crisis. That leaves balances of $224,000 and $257,000.

HE asked if we would start with those balance as we put together the 2019 contract. This was affirmed.

CT asked if they had confirmed that they would continue to serve the 250 clients that the BOH funds.

SS said that in the meeting CHS stated that the BOH money is going to serve the clients.

JB stated that if no action is taken tonight, there would be a delay in funding. Acting would allow Ms. Rodriguez to move forward in negotiations.

HE clarified that if there is a way to do it, she would like to see the number be adjusted to reflect their voluntary reduction in client load with additional amounts being made available if the number of clients goes up.

CR stated that, if there was a better number for per member per month, the BOH would be more comfortable. The challenge is determining if an estimation of how much a client costs is possible. Can that be articulated into a dollar amount through the end of the year? And articulate a separate amount for the approximate 5 new patients a month? If they see those patients, we could pay them that amount.

Motion by Kohlhase/Swanson to approve 7.A1 and 7.A2:

1. Authorizing the Board President to enter into a Contract with the Center for Human Services for the period of May 1, 2019 through December 31, 2019 for Psychiatric Services.
2. Authorizing the Board President to enter into a Contract with the Center for Human Services for the period of May 1, 2019 through December 31, 2019 for Emergency Crisis Intervention Services.

Motion carried.

**8. New Business**

**A. Item to be presented for discussion:**

**1.Embedded Schools Pilot Evaluation proposal**

CR directed members to the proposal to evaluate the project. AH reached out to multiple evaluators. We were only able to obtain one proposal. Part of the difficulty is that the evaluative process was not written into the program. However, there is a proposal from an individual in the community. At this point this is not an actual contract but for BOH review and suggestions. It would be advisable to act on this in May so that the evaluation process could start prior to schools closing.

JB clarified there is this amount in the budget for an evaluation.

**2.Behavioral Health Funding: Timeline for CY20 Funding**

CR shared a draft of the timeline for CY20 Funding. She acknowledged the hard work of the Ad Hoc Funding committee. This funding timeline tries to provide a specificity where we release a NOFO and request for proposals and all the way through the completion of contract. It is a living document. It is recognized that some things may change.

CT complimented all the work that has gone into it. It is coming to a nice place.

**3.McLean County Board of Health Funding Guidelines**

CR thanked everyone for their support. The Funding Guidelines document is an internal document for staff. The Ad Hoc Funding committee suggested production of a smaller version for grantees. It intends to provide a solid guide for us to make a solid funding.

HE and JB complimented everyone that has worked on the document.

SS stated that it will show the community not just the dollars but the outcomes. They want accountability and outcomes.

SR commented that this is not your father's health department. It is not what we knew a generation ago or even three years ago. Hats off to everyone. It is moving us in a direction we needed to go.

JB shared that the next Ad Hoc Funding meeting is on April 24th.

**9. Other**

JB shared that the annual report has been mailed out.

CR stated that because of BOH feedback, the online version has been updated.

JB asked about the status of the video.

CR shared that Ms. Slater is meeting with the videographer to do some last edits this week. The investment in this document and the video has been a third of the cost of what was previously used for printing off the booklet. It is hoped that the video will be finished in the next couple of weeks.

JB asked that Ms. Rodriguez convey to Ms. Slater congratulations. She has elevated her role in this department and made us look great.

**10. Adjournment**

Motion by Reece/Shafer to adjourn.
Motion carried.

Adjournment at 7:25 pm.