



CINCINNATI BOARD OF HEALTH  
Policy Manual  
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MISSION STATEMENT

The Board of Health is responsible for the promotion, protection, and maintenance of the public's health. This responsibility may be achieved by (but is not limited to) development and enforcement of health laws, prevention of disease, education, and curative and rehabilitation activities.

Some governmental functions, while not strictly health services, might be most expeditiously effected via the Board of Health and for that reason should be done by the Board of Health.

The Board of Health's responsibility necessitates involvement with other jurisdictions and agencies, both within and outside the city. This responsibility is sanctioned by the Ohio Revised Code, the Cincinnati Municipal Code, Board of Health Regulations, and by general public health standards.

Adopted: May 27, 1975  
Amended: January 24, 1984



CINCINNATI BOARD OF HEALTH

Policy No. A-2

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BOARD OF HEALTH BY-LAWS

The most recent version of the Board of Health By-laws follow this page.

**BOARD OF HEALTH  
OF THE CITY OF CINCINNATI**

**BY-LAWS**

**ARTICLE I**            **MEMBERSHIP**

Membership of the Board of Health shall be as specified by Article VII, Section 11 of the Charter of the City of Cincinnati.

**ARTICLE II**            **OFFICERS**

Section 1.            The officers of the Board of Health shall be a Chairperson and a Vice Chairperson. Officers shall serve for a term of one year. No person may remain in a particular office for more than two consecutive terms. Only those persons who have at least one (1) year remaining in their term on the Board of Health or who are eligible for re-appointment to the Board of Health shall be eligible to run for office.

Section 2.            Nominations for officers shall be made by the Board members at the meeting prior to the first meeting in September each year and officers shall be elected at the first meeting in September each year.

Section 3.            Members must be present to vote, however, nominee(s) may be absent. The nominee receiving the greatest number of votes shall be declared the winner.

Section 4.            The Chairperson shall preside at all meetings of the Board. The Chairperson shall also appoint the Chairperson of all committees, call special meetings as deemed necessary, set the agenda for all meetings, and act on behalf of the Board regarding communications. By nature of the office, the Chairperson will be an Ex-officio member of all committees and shall perform such other functions as may be determined by the Board.

Section 5.            The Vice Chairperson shall perform the duties of the Chairperson in the event of his/her absence or disability; and, at the Chairperson's request, shall assist the Chairperson in the performance of his/her functions.

Section 6.            In the event of the absence of the Chairperson and Vice Chairperson, the members of the Board present will elect a member to act as Chairperson.

Section 7.            If the Chairperson resigns or becomes permanently unable to fulfill his/her duties as Chairperson, the Vice Chairperson shall assume the role of Chairperson and the Board shall elect a new Vice Chairperson at the next meeting. If the Vice Chairperson declines or is unable to assume the role of

the Chairperson, the Board shall elect a new Chairperson at the next meeting. In the event that the Vice Chairperson resigns or is unable to fulfill his/her role, the Board shall elect a new Vice Chairperson at the next meeting.

Section 8. Officers' terms expire at the end of the meeting at which their successors are elected.

### **ARTICLE III**      **MEETINGS**

Section 1. The Board shall meet not less than once a month, except that the Board may cancel a meeting by a majority vote of those Board members in attendance and voting at any meeting prior to the meeting that is proposed to be cancelled. At least four days' notice of a regularly-scheduled meeting shall be sent to members of the Board. Each Board of Health member will receive an agenda and related materials prior to each meeting.

Section 2. Special meetings may be called by the Chairperson on his/her own initiative. The Chairperson shall call a special meeting upon the written request of no less than three (3) members of the Board. Notice of special meetings stating the purpose thereof shall be given to members of the Board as much in advance as may be feasible. In most instances, this shall not be less than three (3) days.

Section 3. The Board is firmly committed to the letter and spirit of the Ohio Revised Code, Section 121.22. All decision-making by the Board shall be conducted publicly. Consistent with this commitment, executive sessions are permissible as deemed appropriate by the Board, in accordance with the Ohio Revised Code.

Section 4. The presence of a majority of the currently appointed Board members shall constitute a quorum for any meeting.

### **ARTICLE IV**      **COMMITTEES**

The Chairperson may establish committees as needed and may designate their membership.

### **ARTICLE V**      **PARLIAMENTARY AUTHORITY**

Section 1. The rules contained in the current edition of Robert's Rules of Order shall govern the Board in all cases to which they are applicable and in which they

are not inconsistent with these By-Laws and any special rules of order the Board heretofore has adopted or hereafter may adopt.

Section 2. A motion to suspend the statutory rule requiring three readings on separate days is permitted and shall be debatable. On such motion, the major question shall be open to debate. An affirmative vote of three-quarters (3/4) of the currently appointed Board members will be required to approve the motion for suspension of the rule.

Section 3. Except as otherwise provided in these By-laws, or as controlled by statute, any rule may be suspended by the Board by an affirmative vote of a majority of those currently appointed Board members in attendance and voting at any regular or special meeting.

Section 4. In accordance with Section 731.17 of the Ohio Revised Code, all regulations shall be read by title only. However, the Board may require any reading to be done in full upon a majority vote of those currently appointed Board members in attendance and voting at any regular or special meeting.

#### **ARTICLE VI      AMENDMENT OF BY-LAWS**

These By-Laws may be amended by a two-thirds (2/3) vote of those currently appointed Board members in attendance and voting at any regular or special meeting, provided that the amendment has been submitted in writing at the previous meeting.

#### **CINCINNATI BOARD OF HEALTH**

April 10, 1974

Article V amended 7-28-1981

Article IV amended 12-28-1982

Article I and Article IV amended 9-25-1984

Article I, Section 3, amended 11-26-1985

Article IV amended 4-22-1986

Article IV amended 10-27-1987

Article I, II, III, IV, and V amended 12-12-1996

Articles I, II, III, IV and V amended 12-9-2008

Article II, Section II amended 6-26-2012

Article II, Section III amended 8-25-2015

Article II, Section III amended 8-23-2016

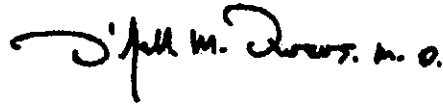
ADOPTED August 23, 2016



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Malcolm Timmons  
Chairperson  
Board of Health of the City of Cincinnati

ATTEST:



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O'Dell Owens, MD, MPH  
Secretary  
Board of Health of the City of Cincinnati





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ADVISORY COMMITTEES TO THE BOARD OF HEALTH

Home Health Services Committee

This Committee is required under Regulation 405.1222 of the Federal Health Insurance for the Aged Program to advise on professional issues, to participate in the evaluation of the Home Health Care Program, and to assist in maintaining liaison with other health care providers in the community and its community information program.

This group of professional personnel “establishes and annually reviews the agency’s policies governing scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, personnel qualifications, and program evaluation.”

Adopted: 1973 and 1975

Amended: September 25, 1984



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### AGENDA

The order of business for Board meetings shall be according to a written agenda prepared by the Chairperson, in conjunction with the Health Commissioner, or their alternates. The written agenda should be presented to all Board members for review prior to the Board meetings. All motions and attachments for inclusion on the agenda must be received by the Chairperson and the Clerk of the Board by noon of the Thursday preceding the Board meeting. Any urgent items not included on the agenda as described above should be referred to the Chairperson, by the Health Commissioner, for special consideration.

It is the Health Commissioner's responsibility to ensure that the agenda and accompanying papers are e-mailed on the Friday prior to the Board meetings.

As to other business that is not on the agenda, the Board may listen to presentations and make and discuss motions but will take no action on original main motions unless all members present and voting are in favor of doing so.

Any member of the Board of Health at a public meeting may request from the Health Commissioner and his/her staff a status report on a particular topic. Such a request for a status report need not be voted upon by the Board unless the Health Commissioner requests such a vote. A written status report will be distributed to the Board members and shall become an attachment to the public agenda of the Board.

The Chairperson may place a time limit of fifteen minutes for each item on the Board of Health agenda. At the end of that time, the Chairperson may go on to the next item, even though the discussion has not been completed. If time permits, the Board may return to the unfinished item.

Adopted: July 27, 1971  
Amended: March 1, 1972  
August 8, 1973  
October 29, 1974  
July 24, 1984; revision effective August 1, 1984  
June 27, 2017



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PREAMBLE TO STATEMENTS REGARDING BOARD OF HEALTH AND HEALTH  
COMMISSIONER OBLIGATIONS AND BOARD OF HEALTH MEMBERSHIP  
OBLIGATIONS

Section 601-1 of the Cincinnati Municipal Code states, “The Board of Health may make such orders and regulations as it may deem necessary for its own government.” Section 601-7 of the Code further states, “The making of decisions . . . may be delegated by the Board of Health to the Health Commissioner, and when so delegated the making of any such decision . . . shall have the same effect as the code of ordinances provides for the opinion, decision, or order of the Board of Health.”

In order for the Board of Health and its staff to manage the affairs of its trust and to meet its legal obligations in a manner consistent with high public expectations, it has at least two organizational responsibilities. First, a contract or definition of relationships between the Board of Health and its chief executive officer must be established. Second, just as the Board’s staff must organize itself to accomplish the tasks and expectations of the organization, so must the Board of Health establish tasks and expectations of its members.

An understanding of the Board of Health and Health Commissioner relationships facilitates trust, openness of communication, goal and objective setting, evaluation of progress, and unity of purpose within the total organization. Such an environment increases the organization’s ability to manage the delivery of significantly improved services to the public.

Board of Health members have responsibilities to each other and to the public they serve to devote the necessary time and energy required to: (1) establish policies leading to accomplish identified departmental goals and objectives; and (2) evaluate the performance of the Health Commissioner and the Health Department. The pursuit of an excellent public health program requires personal commitment commensurate with the level of achievement desired.

STATEMENT REGARDING BOARD OF HEALTH AND HEALTH COMMISSIONER  
OBLIGATIONS

The Board of Health and Health Commissioner will relate to each other in the following manner:

1. Individual Board members are encouraged to communicate questions and concerns directly to the Health Commissioner. The Health Commissioner is encouraged to communicate questions and concerns to individual Board members.

2. When communicating consequential matters with the staff, the Board members will do it through the Health Commissioner.
3. The Health Commissioner will appoint his/her immediate subordinates with the advice and consent of the Board.
4. Once a decision is made, the Board of Health and Health Commissioner will (a) support the decision, and (b) continue to evaluate the decision jointly and directly.
5. The Board will act on Departmental administrative and supervisory matters only through the Health Commissioner.
6. The Board will act as appellate body to the Health Commissioner as required by law and at the request of the Health Commissioner.
7. The Board will limit its depth of involvement in internal matters to that necessary for proper evaluation of progress toward agreed upon objectives.
8. The Health Commissioner will systematically provide the Board with the data they mutually agree necessary to evaluate progress toward objectives.
9. The Board and Health Commissioner expect each other to take the personal risks necessary for the pursuit of excellence.
10. The Board and the Health Commissioner agree to put forth the high level of effort required in the pursuit of excellence.
11. Inquiries by Board members for information requiring appreciable staff time will be requested through the Board.
12. The Health Commissioner, in consultation with the Chairperson of the Board, will be the Board's representative to City Council on formal communications.
13. The Health Commissioner shall be responsible for organizing and presenting to the Board suggested Departmental goals and objectives with action plans and evaluation procedures for approval.
14. The Health Commissioner is expected to operate the Health Department within the policies approved by the Board and to refer suggested policy changes and new policies to the Board for approval.
15. The Board will formally evaluate the performance of the Health Commissioner annually.
16. The Board will provide the Health Commissioner with an evaluation statement of the Department's performance annually.

17. Any major departmental change proposed by a Health Commissioner – changes of an organizational, programmatic, budgetary, or staffing nature – must be presented to the Board of Health for prior approval.

#### STATEMENT REGARDING BOARD OF HEALTH MEMBERSHIP OBLIGATIONS

Board of Health members are expected to strive for excellence by performing their duties as a member of the Board by:

1. Attending a minimum of 2/3 of all Board and assigned Committee meetings;
2. Attending special meetings on a consistent basis;
3. Studying written materials in advance of meetings;
4. Being an advocate of public health;
5. Supporting publicly the policies made by the Board once those policies are established;
6. Sharing expertise and special knowledge with the Board of Health and the Health Commissioner;
7. Officially representing the Board of Health by being on the agenda of at least three community gatherings each year;
8. Attending where possible other health-related meetings in the community;
9. Being knowledgeable about the Board of Health's By-Laws, policies, and legal responsibilities;
10. Continuing their education in public health matters;
11. Taking the personal risks necessary;
12. Following the written policy on Board of Health and Health Commissioner Obligations.

Should a Board member not meet these expectations to a satisfactory degree, any two Board members or the Chairperson may open this matter for discussion. Board members unwilling to share in this process or to make mutually agreed upon improvements will be expected to resign.

Adopted: October 28, 1975  
Reaffirmed: February 26, 1985  
Amended: April 22, 1986  
Amended: September 26, 2017



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PUBLIC NOTICE OF BOARD OF HEALTH MEETINGS

1. Notification is to be sent in accordance with the requirements of the Ohio Open Meetings Act, Ohio Revised Code Section 121.22. Notification shall be made to any members of the news media who have requested notification and to the Clerk of Council for publication in THE CITY BULLETIN prior to each meeting.
2. Notification shall also be sent to any other concerned individuals who have requested to be notified of Board of Health meetings.
3. Any required notification under the Ohio Open Meetings Act or this Policy may be accomplished via email.

Adopted: March 28, 1978  
Amended: July 24, 1984; effective date August 1, 1984  
Amended: July 25, 2017



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PRESENTATIONS FROM MEMBERS OF THE PUBLIC  
AT BOARD OF HEALTH MEETINGS

1. The primary purpose of the Board of Health meetings is for the Board of Health to conduct its business in an orderly fashion and in public. It is not intended to be an open forum for discussion of the public's views on public health matters.
2. This Policy applies to both committee meetings and meetings of the full Board. The only difference between meetings of the Board of Health and Committees is that the Board of Health is the decision-making body, which accepts recommendations from the Committees.
3. If anyone wishes to speak at the meeting, they should register their names and what organization they represent, if any, with the Clerk of the Board of Health. Each person must complete the appropriate card or form as required by the Clerk to organize the requests.
4. To control and develop orderly input, no one will be allowed to speak in an impromptu fashion to the Board of Health during the public hearings, unless otherwise recognized by the Chairperson.
5. In general each person may be allowed a limited time to speak or to read a prepared statement, depending on how many people want to speak, how many items are on the agenda, and other time considerations for a particular meeting. The only content consideration is that speakers must speak to a topic related to the business of the Board of Health and the Health Department. The Chairperson of the hearing is to use his/her judgment if speakers talk beyond the time allotted for each speaker for that meeting or if the speakers become repetitive or argumentative.
6. The conduct of the hearing is to be determined by the Chairperson of the hearing.
7. A person or group who wishes to make a formal, extended presentation to the Board of Health should contact the Health Commissioner, a Board member, or the Clerk of the Board of Health in advance of the meeting to request that the presentation be placed on the agenda. There is no right to make a presentation to the Board of Health. Whether a person or entity is provided time at a meeting for a presentation is at the discretion of the Board and the Health Commissioner.

8. No citizen or group should dominate the discussion time. If this occurs, the Chairperson should stop such interference. If necessary, person interfering with the meeting may be removed from the meeting. If a disturbance is so widespread that the Board or Committee is not able to conduct business in its normal fashion, the Chair can adjourn the meeting.

Adopted: March 28, 1978  
Amended: April 22, 1986  
Amended: September 22, 1987  
Amended: July 25, 2017





MEETING TIMES

The Board of Health public, formal meetings will be held on the fourth Tuesday of every month at 6 p.m. Emergency public meetings will be called at the discretion of the Chairperson of the Board of Health.

Adopted:      January 27, 1975  
Amended:    April 25, 1978  
                  May 22, 1984



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OPEN BOARD OF HEALTH MEETINGS

1. All meetings of the Board of Health will be public as provided by law.
2. The time and place of future Board or Committee meetings shall be announced to the public at the prior meeting and/or Board meeting whenever possible.

Adopted: February 25, 1975

Amended: July 24, 1984; effective date August 1, 1984



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PUBLIC NOTICE OF REGULAR AND SPECIAL MEETINGS

Notice of the time and place of regularly-scheduled meetings of the Cincinnati Board of Health and Committee meetings shall be published in advance of such meeting in THE CITY BULLETIN, the official publication of the City of Cincinnati. Notice of the time, place, and purpose of all meetings will be available in the office of the Clerk of the Board of Health, Room 111, 3101 Burnet Avenue.

Special meetings of the Board of Health shall not be held unless twenty-four hours' advance notice is given to the news media. In the event of an emergency requiring immediate official action, the appropriate Health Department staff shall notify the news media of the time, place, and purpose for such meeting.

Any person who wishes to obtain advance notification of all meetings at which any specific type of public business is to be discussed shall submit a written request for such notification to the Cincinnati Board of Health, 3101 Burnet Avenue, Cincinnati, OH 45229. Such requests shall include the name, address, and telephone number of the person making the request. It shall be the responsibility of the requestor to report changes of address.

Adopted: November 25, 1975  
Amended: April 22, 1986



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REIMBURSEMENT OF EXPENSES FOR BOARD OF HEALTH MEMBERS

The Commissioner of Health will maintain within the office budget a line item for miscellaneous Board of Health expenses, in an amount not to exceed \$3,000, for the purpose of reimbursing Board of Health members for out-of-pocket expenses incurred as a result of conducting official Board of Health activities.

This line item shall include, but not be limited, to the following expenses:

- Local travel;
- Meals, including taxis and tips;
- Long distance telephone calls;
- Registration fees (for meetings);
- Books and periodicals.

Adopted: June 24, 1975

Amended: September 25, 1984



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SECONDS TO MOTIONS AND ROLL CALL VOTES

Seconds to motions and roll call votes in rotating order will be routine on all issues coming before the Board. Roll call votes will not be necessary for approval of minutes or for adjournment.

Adopted:      October 8, 1974  
Amended:     May 22, 1984



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BOARD OF HEALTH MEMBERS/HEALTH DEPARTMENT EMPLOYEES SERVING ON  
OTHER BOARDS

Board of Health members and Health Department employees are encouraged to increase communication and coordination with other community service and health-related agencies. They also need to offer their expertise and experience to the Greater Cincinnati community.

To this end, the Board of Health approves of and supports its members and employees serving on boards of community service and health-related agencies. Their activities should be consistent with Ohio Revised Code Section 2921.42(A)(4) which provides:

“No public official shall knowingly...have an interest in the profits or benefits of a public contract entered into by or for the use of the political subdivision or governmental agency or instrumentality with which he\* is connected.”

\*"He" used in this Policy statement is arbitrary and meant to represent all persons, male and female, indicated by the context.

Adopted: April 27, 1982  
Amended: April 22, 1986



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ELECTION OF OFFICERS

Nominations for the offices of Chairperson and Vice Chairperson for the Board of Health will be made at the August meeting each year. Nominations will be made orally from the floor by Board of Health members.

A list of Board members eligible for nomination will be provided at the meeting where nominations occur. Per the Board of Health By-Laws, Article II, Section 1, no member may remain in a particular office for more than two consecutive terms.

The election of officers will be done by roll call vote at the September Board of Health meeting each year per the By-Laws, Article II, Sections 2.

The voting is governed by the By-Laws, Article II, Section 3, which requires that members must be present to vote, that nominees may be absent, and that the nominee receiving the greatest number of votes shall be elected.

Adopted: June 22, 1993  
Amended: May 23, 2017





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### CONFLICT OF INTEREST POLICY

It is in the best interest of the Board of Health of the City of Cincinnati (the “Board”) to identify and manage all conflicts of interest and appearances of conflicts of interest. This policy is designed to help Board members identify potential conflicts and to provide the Board with a procedure to appropriately manage conflicts. The Law Department is available to assist regarding potential conflict issues and, if necessary, to provide opinions as to whether a particular situation or relationship amounts to a conflict of interest.

**Conflict of Interest Basic Rules and Resources.** The Board is governed by Ohio Revised Code (ORC) § 102.03, § 2921.42, and other related sections of Ohio law regarding conflicts of interests and ethical conduct of public officials. The following are some of the provisions of ORC § 102.03 pursuant to which a Board member may have a conflict of interest:

1. A Board member (or family member) is a party to a contract with the Board, or involved in a transaction with the Board, for goods or services.
2. A Board member (or family member) has a financial interest in a transaction between the Board and an entity in which the Board member or a family member is a director, officer, agent, partner, associate, employee, trustee, personal representative, receiver, guardian, custodian, or other legal representative.
3. A Board member (or family member) has a financial interest in a business or enterprise that competes with the Board, or is engaged in some capacity with a competing business or enterprise.

Board members should be aware of the Ohio Ethics Commission and should review its publication, “Ohio Ethics Law Memoranda For Board and Commission Members,” which summarizes and explains the relevant Ohio law regarding conflicts of interest, prior to beginning service on the Board of Health.

Board of Health Policy No. B-12 addresses the ability to serve on other boards and should be read in conjunction with this Policy No. B-14.

**Appearance of a Conflict of Interest.** Other situations may create the appearance of a conflict of interest in connection with members of the Board, members of the Cincinnati Health Department, or any parties who have contracts with the Board or may be interested in doing business with the Board. All such circumstances should also be disclosed to the Board and a



decision made as to what course of action the Board should take so that the best interests of the Board are not compromised.

**Gifts, Entertainment, Other Items of Value.** Accepting gifts, entertainment, or other items of value from individuals or entities can also result in a conflict of interest whenever it might be inferred that such action was intended to influence the Board member in the performance of his or her duties. This rule does not preclude the acceptance of items or entertainment of nominal or insignificant value that are not related to any particular transaction or activity of Board.

### **Identifying Conflicts of Interest.**

1. When a new member begins service on the Board of Health, he or she shall complete the “Conflict of Interest Disclosure Form,” attached as an Exhibit to this Policy, to identify any potential conflicts of interest based on the member’s current memberships, employment, affiliations, fiduciary or familial relationships, or other associations.
2. Prior to Board or committee action on a contract, transaction, or other business involving a potential conflict of interest for a Board member, that member shall determine whether the potential conflict constitutes a conflict such that the member should not participate in Board business related to the matter giving rise to the conflict. The Board member may seek legal advice from the Law Department regarding whether a conflict exists..
3. If Board members are aware that Cincinnati Health Department staff or other volunteers affiliated with the Board of Health have a conflict of interest, relevant facts should be disclosed by a Board member or by the interested staff member or volunteer before discussion of the contract, transaction, or other business to which the conflict is related.

### **Addressing Conflicts of Interest.**

1. A person who has a conflict of interest shall not participate in or be permitted to hear the Board’s or committee’s discussion of the matter. Such person shall not attempt to exert his or her personal influence with respect to the matter.
2. The person having a conflict of interest may not vote on the contract, transaction, or other business and shall not be present in the meeting room when the vote is taken. Such person’s ineligibility to vote shall be reflected in the minutes of the meeting.
3. A Board member who has a conflict of interest with regard to a contract, transaction, or other business shall not be counted in determining the presence of a quorum for purposes of the vote on that matter (either as a present or absent member, or as one of the total number of members of the Board or committee).

Adopted:      September 27, 2016

**Cincinnati Board of Health  
Conflict of Interest Disclosure Form**

Name: \_\_\_\_\_

Please specify other nonprofit and for-profit boards of which you (or your spouse) are a member; any for-profit businesses in which you or an immediate family member are an officer, director, owner, partner, or majority shareholder; and any entity for which you serve in a fiduciary capacity:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Or: I do not have such an interest in any business. \_\_\_\_\_ (initial)

I hereby certify that the information set forth above is true and complete to the best of my knowledge. I have reviewed, and agree to abide by, Board of Health Policy Nos. B-12 and B-14, O.R.C. §§ 102.03 and 2921.42, and the current version of the Ohio Ethics Commission's "Ohio Ethics Law Memoranda for Board and Commission Members."

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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PRINCIPLES OF THE ETHICAL PRACTICE OF PUBLIC HEALTH

**I. Principles of Ethical Practice**

The Board of Health recognizes and adopts the following Principles of the Ethical Practice of Public Health:

1. Public health should principally address the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.
2. Public health should achieve community health in a way that respects the rights of individuals in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.
5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.
6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.
7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.
8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.
9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.
10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on

the basis of the high likelihood of significant harm to the individual or others.

11. Public health institutions should ensure the professional competence of their employees.
12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

## **II. Values and Beliefs Underlying Principles**

The following values and beliefs are key assumptions inherent to a public health perspective. They underlie the Principles of the Ethical Practice of Public Health.

### ***Health:***

1. *Humans have a right to the resources necessary for health.* The Public Health Code of Ethics affirms Article 25 of the Universal Declaration of Human Rights, which states in part, "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family..."

### ***Community:***

2. *Humans are inherently social and interdependent.* Humans look to each other for companionship in friendships, families, and community and rely upon one another for safety and survival. Positive relationships among individuals and positive collaborations among institutions are signs of a healthy community. The rightful concern for the physical individuality of humans and one's right to make decisions for oneself must be balanced against the fact that each person's actions affect other people.
3. *The effectiveness of institutions depends heavily on the public's trust.* Factors that contribute to trust in an institution include the following actions on the part of the institution: communication, truth telling, transparency (i.e. not concealing information), accountability, reliability, and reciprocity. One critical form of reciprocity and communication is listening to as well as speaking with the community.
4. *Collaboration is a key element to public health.* The public health infrastructure of a society is composed of a wide variety of agencies and professional disciplines. To be effective, they must work together well. Moreover, new collaborations will be needed to rise to new public health challenges.
5. *People and their physical environment are interdependent.* People depend upon the resources of their natural and constructed environments for life itself. A damaged or unbalanced natural environment, and a constructed environment of poor design or in poor condition, will have an adverse effect on the health of people. Conversely, people can have a profound effect on their natural environment through consumption of resources and generation of waste.

6. *Each person in a community should have an opportunity to contribute to public discourse.* Contributions to discourse may occur through a direct or a representative system of government. In the process of developing and evaluating policy, it is important to discern whether all who would like to contribute to the discussion have an opportunity to do so, even though expressing a concern does not mean that it will necessarily be addressed in the final policy.
7. *Identifying and promoting the fundamental requirements for health in a community are of primary concern to public health.* The way in which a society is structured is reflected in the health of a community. The primary concern of public health is with these underlying structural aspects. While some important public health programs are curative in nature, the field as a whole must never lose sight of underlying causes and prevention. Because fundamental social structures affect many aspects of health, addressing the fundamental causes rather than more proximate causes is more truly preventive.

***Bases for Action:***

8. *Knowledge is important and powerful.* Those in the public health field are to seek to improve their understanding of health and the means of protecting it through research and the accumulation of knowledge. Once obtained, there is a moral obligation in some instances to share what is known. For example, active and informed participation in policy-making processes requires access to relevant information. In other instances, such as information provided in confidence, there is an obligation to protect information.
9. *Science is the basis for much of our public health knowledge.* The scientific method provides a relatively objective means of identifying the factors necessary for health in a population, and for evaluating policies and programs to protect and promote health. The full range of scientific tools including both quantitative and qualitative methods, and collaboration among the sciences, is needed.
10. *People are responsible to act on the basis of what they know.* Knowledge is not morally neutral and often demands action. Moreover, information is not to be gathered for idle interest. Public health should seek to translate available information into timely action. Often, the action required is research to fill in the gaps of what is not known.
11. *Action is not based on information alone.* In many instances, action is required in the absence of all the information one would like. In other instances, policies are demanded by the fundamental value and dignity of each human being, even if implementing them is not calculated to be optimally efficient or cost-beneficial. In both of these situations, values inform the application of information or the action in the absence of information.

Adopted: September 26, 2017



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AFFIRMATIVE ACTION

The Cincinnati Board of Health supports the Affirmative Action Policy of the City of Cincinnati (see attached).

It is the policy of the Cincinnati Board of Health that additional efforts be made to recruit, hire, train, and promote qualified members of groups that formerly were excluded. It is further the intent of the Board to maintain a balanced, responsive, and productive work force which will reflect an equitable distribution of protected group members.

The Health Commissioner is committed to implement directives of the Board by ensuring the Department's compliance to the Equal Employment Opportunity Act of 1972. Through this Act, the Board of Health is subject to the anti-job Act of 1964. Title VII bans discrimination on the basis of race, age, color, sex, religion, or national origin in all terms and conditions of employment. In addition to this Act, the Board of Health supports the Rehabilitation Act of 1973 that prohibits local government from discriminating against the handicapped.

Attachment: 1  
Adopted: October 27, 1981  
Amended: November 27, 1984





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## AIDS-RELATED POLICIES AND GUIDELINES

### **1. Policy Statement: Reporting**

All health providers diagnosing individuals as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) must complete the Confidential Case Report Form (AIDS) or the Confidential Case Report Card (ARC) and forward these reports to the STD/AIDS Control Program, Cincinnati Health Department. It is important to emphasize that an HIV antibody positive test result in a patient not having symptoms of HIV infection is not, by law, reportable in Ohio at this time.

Background: Effective 10/83, AIDS, and 3/86, ARC, are Class A reportable communicable diseases through revision of the Ohio Revised Code. All reports are confidentially transmitted from the Cincinnati Health Department to the Ohio Department of Health. Each physician will receive a personal consultation from the STD/AIDS Control Program staff prior to any follow-up activity regarding any case report. The AIDS Related Complex (ARC) surveillance definition, Ohio Department of Health, will assist physicians in determining patient diagnostic status.

**Please see Attachments #1, #2, #3, and #4.**

### **2. Policy Statement: AIDS Virus (HIV) Antibody Testing**

The AIDS virus (HIV) antibody test was developed to screen units of blood. The test should not be used to screen the general population or to mass screen captive populations such as school children, institutionalized individuals, or applicants for such services as foster care or day care. It is inappropriate to use this test as a precondition for employment, hospital admission, or as evidence of insurability. If a patient documents either high-risk group identifiers or sexual contact to the same – e.g., homosexual or bi-sexual man, intravenous drug user, hemophiliac, or prostitute – the attending physician may want to perform the HIV antibody test. In this situation, the patient must be informed of the physician's intent to test; and he/she must consent. Since a positive HIV antibody result indicates intermittent viral presence in the majority of individuals, this may have diagnostic relevance to the presenting patient's medical condition.

In the process of informing the patient of his/her HIV antibody positivity, it is imperative for the attending physician to either personally counsel the patient or arrange for on-the-spot counseling from a mental health professional experienced in HIV counseling.

Background: The use of this test for the purpose of screening blood samples for the AIDS virus has led to a much safer blood supply. It is important to emphasize that the HIV antibody test is not a test to detect the disease called AIDS (Acquired Immune Deficiency Syndrome). However, a true positive antibody test indicates the person has been exposed to the HIV virus. This test should not be used to screen groups of low-risk individuals. The test can have value in





identifying those high-risk individuals who have been exposed to the HIV virus. Accordingly, screening of high-risk individuals for HIV virus has potential to curtail spread of the virus.

Such voluntary and anonymous antibody screening as offered by the Cincinnati Health Department alternate education/testing site should be encouraged, with routine specialized pre-test and post-test counseling. Persons at high risk for contracting AIDS infection include gay and bisexual males, persons sharing hypodermic needles (usually IV drug users), hemophiliacs, prostitutes, and persons who have had sexual contact with someone who is at increased risk of exposure to the HIV viral antibodies.

In private practice or clinics where anonymous testing is impractical or otherwise undesirable, the physician must ensure the highest level of patient confidentiality regarding HIV laboratory results and AIDS or ARC-related medical records. The Ohio Department of Health offers recommendations for clinic management of HIV infection. Before testing an individual's serum for HIV antibody, that person must be informed of the intention to test; and the implications of a positive or a negative test should be discussed. Physicians should obtain patient written consent before proceeding with the test. If these conditions cannot be adequately met, the physician should refer the individual to an HIV alternate education/testing site such as the Cincinnati Health Department.

On-the-spot patient counseling is stressed for persons who have been found to be HIV antibody positive because of the traumatic effect on the client. Special counseling issues relative to HIV positive antibody status are continuing medical care, partner notification, avoidance of viral spread, insurability, potential discrimination effects (housing, employment, and insurability); and understanding differences between HIV positivity, symptomatic HIV infection, AIDS-Related Disorders (ARD), and Acquired Immune Deficiency Syndrome (AIDS).

**Please see Attachments #5, #6, #7 and #8.**

### **3. Policy Statement: Control Measures**

The Cincinnati Health Department STD/AIDS Control and Prevention Program will continue and expand the adaptation and application of proven STD control measures to achieve some practical level of control in the spread of the AIDS virus through the local high-risk groups. Quarantine is not warranted for an entire class or group of individuals who are HIV antibody reactive. Medical isolation of persons should be considered only as a last resort in dealing with incorrigible HIV antibody positive individuals who knowingly and directly infect others through sexual contact or through the sharing of needles during intravenous drug abuse.

**Background:** These control measures include availability of early medical detection of disease, anonymous and voluntary HIV antibody testing, telephone hotline services, and dissemination of community-based AIDS education and risk reduction information.





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Transmission of the HIV virus occurs through consensual acts, either sexually or through sharing of hypodermic needles; or coincidentally via direct contamination with infected blood or blood products (blood transfusion, blood component transfusion); or through prenatal maternal transfer of antibodies and postnatal transfer through infected breast milk. Consequently, quarantine issues regarding AIDS and HIV infection are substantively different from those diseases where transmission may be documented through less specific or broader methods.

**Please see Attachment #9 and #10.**

#### **4. Policy Statement: Schools and Foster Care Centers**

The Cincinnati Board of Health endorses the school and foster care center recommendations for HIV infected children issued August 30, 1985, by the Centers for Disease Control; and the Ohio Department of Health similar guidelines dated September 1987. Recognition of a child with AIDS/HIV is not reason for exclusion from school. Each child should be evaluated as an individual case, and his/her inclusion or exclusion from the classroom should be based upon the child's physical limitations, psychosocial activity patterns, and the opinion of a panel to include: the child's parents, medical representative of the Health Department, the attending physician, and the appropriate school official.

Background: Based upon current evidence, casual person-to-person contact as would occur among school children appears to pose no risk for transmission of HIV. Theoretical potential for AIDS transmission may exist among younger children without toilet training, or neurologically handicapped children who lack control of the body secretions or who display aggressive behavior such as biting. It should be emphasized that, in theory, transmission would most likely involve exposure of open skin lesions or mucous membranes to an infected HIV individual's blood, male reproductive fluid, vaginal fluid, and feces. The wearing of gloves in handling these body fluids would provide adequate protection against exposure to the HIV as in any routine health care setting.

**Please see Attachments #11 and #12.**

#### **5. Policy Statement: HIV Transmission in the Workplace**

Persons known to be infected with the HIV virus should not be restricted from work unless they have another infection or illness for which such restriction would be warranted. However, certain health care workers (HCW) and personal service workers (PSW) may be evaluated to return to the workplace on an individual case-by-case basis. These employee groups are defined in the Centers for Disease Control policy dated November 15, 1985.

Background: AIDS has been found to be a bloodborn or sexually transmitted disease that is not spread by casual contact. AIDS is not transmitted through the preparation or serving of food and beverages or through the performance of other personal service duties. There is no known risk of



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AIDS transmission in other work settings—e.g., offices, schools, factories, and construction sites.

Please see Attachment #13.

#### **6. Policy Statement: HIV Infection in the Health Care Setting**

Special attention to routine, standard infection control procedures currently used to avoid exposure to any known blood or body fluid-borne infection should be strictly enforced in all health care delivery and emergency care services. All health care facilities should have a specific policy dealing with injuries by accidental needlestick and procedures to protect workers from blood and body fluids.

Procedures should include:

- a. Extraordinary care should be taken to prevent accidental injuries when handling sharp items (needles, scalpel blades, sharp instruments, etc.);
- b. Disposable syringes and needles, etc., should be placed in puncture-resistant containers;
- c. To prevent needlestick injuries, needles should not be recapped, should not be purposefully bent, should not be broken, or should not be otherwise manipulated by hand;
- d. Gloves should be worn when the possibility of exposure to blood or other body fluids exists while handling patients;
- e. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood;
- f. Although saliva has not been implicated in HIV transmission, protection from potential exposure to other internal body fluids during resuscitation can be provided by using resuscitation bags, mouth-to-mouth resuscitation mouthpieces, or other ventilation devices during cardiopulmonary resuscitation;
- g. Health care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care from handling patient care equipment, and from handling patient laboratory specimens until the condition resolves unless the condition can be protected by utilizing routine infection control procedures;

For detailed HIV prevention recommendations regarding special health care settings (e.g., dentistry, dialysis, morticians' services, etc.), please see Attachment





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#14 (Recommendations for Prevention of HIV Transmission in Health Care Settings, August 21, 1987);

- h. All health care agencies must develop a policy by which appropriate direct care providers can access information on the HIV status of the patient. There can be notation in the medical record that the HIV test has been drawn.

Background: In many health care institutions, numerous employees other than direct care providers have access to the patient record. Consequently, any system that places the HIV test results on the patient record potentially jeopardizes patient confidentiality and may raise unfounded fears for those unfamiliar with the proven routes of transmission;

- i. Any health care personnel infected with HIV virus will be reviewed on a case-by-case basis as to his/her work assignment.

**Please see Attachment #14.**

**These policies and guidelines are subject to revision at any time depending upon the availability of new scientific information on Acquired Immune Deficiency Syndrome (AIDS).**

Adopted: April 22, 1986  
Amended: May 26, 1987  
January 26, 1988



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AUTHORIZATION FOR THE CLERK OF THE BOARD TO SIGN TRAVEL REQUESTS  
AND TIME SHEETS FOR THE HEALTH COMMISSIONER

The Clerk of the Board of Health is authorized to sign travel requests and time sheets for the Health Commissioner if the Chairperson or his/her designee is not immediately available or if the Chairperson so designates.

Adopted:      December 15, 1975  
Amended:     February 26, 1985



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CLINICAL RECORD RETENTION AND MICROFILMING POLICY AND PROCEDURE

The Board of Health agrees that there will be a record retention policy schedule developed and implemented by the Cincinnati Health Department staff.

Adopted: November 23, 1976

Amended: October 23, 1984



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### POLICY ON CONFIDENTIALITY

The Board of Health adopts the following privacy/confidentiality policy to assure that patient/client information is maintained in compliance with Section 1347 of the Ohio Revised Code.

1. Inform the Patient/Client. Upon registering for service, each person is informed of the kinds of records maintained for patient/client care; how the record is used; the patient/client's right to read, copy, and request correction of a record about himself/herself; whether information requested is required by law; and the effect on him/her, if any, of not providing requested information.
2. Permit First Party Access. Patient/Clients can read their records. A provider reviews records to insure that information would not detrimentally affect the patient/client. The patient/client selects a provider outside the Department to receive a copy of the record if the Department's reviewing provider denies access.

Parents of minors under age 12 can exercise first party access to their children's records. Parents of unemancipated minors 12 years of age and older need their minor child's consent for first party access for any information other than immunization records.

3. Permit Challenge of Records. Patients/Clients can challenge the accuracy and relevancy of information. Either the record is changed, or information of their challenges becomes part of the records.
4. Provide Security. Active records/information are maintained in a physically and technically secure manner. All staff, students, and volunteer sign security pledges. Administrators are responsible for seeing that the staff and work areas comply with security and confidentiality rules.
5. Storage. All personally-identifiable, inactive records (except personnel records) are to be stored and microfilmed (if appropriate) at Medical Records and Billing, Health Department. Appropriate indexes and logs are maintained by Medical Records and Billing.

All outdated records, including computer records, are shredded.

6. Restrict Third Party Access. Release of patient/client information will not be made without written authorization of the patient/client unless the disclosure would be the routine transfer of information among treatment personnel, or per law (Cancer Registry, subpoena, auditors, etc.).





Routine transfers of patient/client information in and outside the Department are described in the annual "Notices of Personal Information Systems" filed with the Ohio Privacy Board. Transfers must be compatible with the purpose for which information is collected.

7. Restrict Research Use. Researchers needing individually identifiable patient/client information must apply for such a research privilege with the Institutional Review Board. Research proposals and protocols are then reviewed to insure that potential benefits are greater than risks (including disclosure risk) and that extent to which the research can protect the confidentiality of the records. Consent issues are considered.

And further, that the Cincinnati Health Department develop, maintain, and distribute procedures to implement the privacy/confidentiality policy.

Adopted: April 28, 1981  
Amended: April 22, 1986



CONTRACT/GRANT/LEASE MANAGEMENT

1. All contracts for professional services amounting to more than \$15,000 in a single contract with amendments or during an automatic renewal period require the approval of the Board of Health. Contracts approved by the Board of Health must bear the signature of the Chairperson of the Board of Health or the Chairperson’s designee.
2. The Health Commissioner can approve all contracts for professional services less than and equal to \$15,000 including amendments or during an automatic renewal period with notification to the Board of Health.
3. Notification to the Board of Health by the Health Commissioner shall include information on (a) term of contract; (b) amount of contract; (c) impact on personnel; (d) summary of service.
4. The following criteria shall govern requirements of Board of Health approval for amendments to contracts for professional services:
  - A. Contracts less than and equal to \$15,000 (including the amended amount) can be amended by the Health Commissioner with notification to the Board of Health;
  - B. Contracts amounting to more than \$15,000 (including the amended amount) require Board of Health approval for amendments that alter the original terms in one or more of the following respects:
    - (1) expenditure of more money than specified under the original contract;
    - (2) reduction in the quantity and/or quality of service without a corresponding and proportional reduction of expenditures;
    - (3) expenditure of money sooner than specified under the original schedule of payments and without proportional advancement in the performance schedule.
5. All grants and leases of property regardless of the amount require the approval of the Board of Health and must bear the signature of the Chairperson of the Board of Health or the Chairperson’s designee.

Original Policy Adopted: December 12, 1978  
Amended: September 23, 1980  
Amended: February 24, 1981  
Amended: August 24, 1982  
Amended: December 18, 1984  
Amended: March 25, 2003

Amended

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EVALUATION OF THE HEALTH COMMISSIONER

Annually, the Health Commissioner shall submit to the Board of Health a report for the previous year-long period, and the measurable goals and objectives for the coming year. The Health Commissioner's evaluation and the Board of Health's comments on, edits to, and approval of the goals and objectives will occur at the next Board of Health meeting after the Commissioner has submitted the report.

Adopted: November 25, 1975  
Amended: February 26, 1985  
Amended: May 23, 2017



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FEES AND PATIENT CHARGES

The Board of Health shall use a schedule of discounts which allows the Health Department to determine the percentage of the cost of primary health care services for which an individual will be responsible. This schedule is based upon the current Community Services Administration (CSA) Income Poverty Guidelines, plus 25%. Section 330 Federal Regulations, Section 51C 303 requires a schedule of discounts based on these income guidelines to be used by all agencies receiving 330 funds. This schedule will be updated annually to conform with the new CSA Poverty Guidelines.

Criteria for eligibility of persons to receive services are stated in Board of Health Regulation 00073-7 (please see attached).

Attachments: 3

Adopted: November 23, 1976

Amended: October 23, 1984



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FUNDING FOR HEALTH AND HEALTH-RELATED SERVICES

There shall be guidelines developed to facilitate the appraisal of proposals for funding health and health-related services provided by community groups or other non-profit agencies. These guidelines might include the following areas:

1. Governing Board;
2. Major Services Offered;
3. Expenditures;
4. Financial Transactions and Accountability;
5. Administrative Records and Controls.

Adopted: October 28, 1975  
Amended: March 25, 1986



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GUIDELINES FOR STAFF TRAVEL

The Board of Health delegates its authority to the Health Commissioner to approve expenditures for travel in the line of Departmental business.

All travel requests must be approved in advance of the proposed travel. Requests for approval of travel already completed will not be approved unless a justifiable reason for not seeking prior approval is provided.

Adopted: September 28, 1971

Amended: November 27, 1984



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MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS

The Board of Health approves the Health Commissioner's membership in professional organizations as deemed appropriate or necessary for the best interests of the Health Department.

The Board of Health also authorizes the payment by the City of Cincinnati for membership to professional organizations, such as the Academy of Medicine, where such memberships are required as a working condition; for example, as a requirement by an insurance company that in order for the City to purchase medical liability insurance, the physicians must be members of the Academy of Medicine.

Adopted: September 24, 1974

Amended: April 25, 1978

February 26, 1985

September 3, 1986



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EMPLOYEE PARKING POLICY

Free parking at the employee's base work site will not be provided, if there is any cost to the Department, for employees who remain at one location all day. Reimbursement for parking costs at other than the employee's base work site will continue to be made in accordance with City policies and procedures.

Parking will be provided, where feasible, when the users must move from one location to another and when it is in the interests of the Department to avoid undue delay in transit, make movement from location to location feasible, or significantly enhance the safety of employees.

Adopted: July 27, 1971  
Amended: November 27, 1984





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PATIENT RESIDENCY FOR PRIMARY HEALTH CARE SYSTEM

The following persons will be eligible to utilize services offered at or by the Cincinnati Health Department Centers:

1. All residents of the city of Cincinnati;
2. Residents of Hamilton County who live outside the limits of the city of Cincinnati who are:
  - a. Covered by Medicaid and/or Medicare;
  - b. Enrollees of MagnaCare or other prepaid health programs;
  - c. Covered by special program funding provided by other than the City of Cincinnati;
  - d. Private insurance.
  - e. If the insurance does not cover the full cost of care, then the County resident will be required to pay any difference.

Discontinuation of Service to County Residents Who Reside Outside the city of Cincinnati Limits

For those persons who had received services at a Cincinnati Health Department Center by means of special funding, a reasonable time period for discontinuance or termination of service will be granted. The determination of the time period will take into consideration the individual's health needs and the availability of alternate service providers; but in no one case will service be continued beyond six months unless the individual re-qualifies under one of the other conditions.

Emergency Care

All patients who request to receive a service from one of the Cincinnati Health Department health centers will be asked where they reside and will be informed of these residency requirements. If they do not meet one of these requirements, staff will assist them in finding an alternative service provider; however, if they are in the health center and in need of immediate care, they will be seen for treatment of that immediate problem and then be referred elsewhere for continuing care.

Adopted: July 22, 1986



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## PROCEDURES FOR PERSONNEL ACTIONS

### 1. NORMAL PROCESS

The procedures that we are recommending to handle the normal process for new appointments, promotion, demotions, and disciplinary actions are as follows:

#### A. New Appointments

1. New appointments to the Health Department will be included in the Board of Health supplemental packets.
2. Since most new appointments to the Health Department do not have employee numbers, they will be listed by name, classification, and program.

#### B. Promotions

1. Promotions within the Health Department will be included in the Board of Health supplemental packets.
2. Promotions will be listed by the employee's Civil Service assigned number, classification employee is being promoted to, and program.

#### C. Demotions

1. Demotions will be included in the Board of Health supplemental packets.
2. Demotions will be listed by the employee's Civil Service assigned number, the classification that the employee is being demoted from, the classification the employee is being demoted to, and the programs affected by the demotion.

#### D. Disciplinary Actions

1. All disciplinary actions which would require actions greater than written reprimands, oral reprimands, or Public Employee Assistant Program (PEAP) referral will be submitted to the Board in the Board of Health supplemental packets.
2. Disciplinary actions will be listed by the employee's Civil Service assigned number, the classification of the employee, a statement of the charges against the employee, and the recommended disciplinary action.

## II. EXCEPTION PROCESS





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From time to time, situations may arise whereby some personnel actions will need to be implemented prior to a public Board of Health meeting. This situation will be of a rare occurrence and will be submitted on a case-by-case basis. This procedure basically will be used to prevent situations of moral obligation and to prevent situations where a program may be severely handicapped if certain personnel actions are not implemented in a timely manner.

A. Procedure for the Exception Process

1. The Health Commissioner or his/her designee will contact the Board of Health Chairperson and provide justification for implementing an exception to the normal process.
2. If the Chairperson of the Board of Health is in agreement, the Chairperson may contact other Board members to get the necessary majority agreement to tentatively approve the actions requested.
3. At the following meeting, the Board of Health will officially approve the action requested. All these actions will be included in the supplemental Board packets.

B. Examples of an Urgent Situation Could be as Follows:

1. The need to employ a physician to work in a clinic where we have no other physicians available to provide the necessary medical services. The procedure outlined could be used to avoid closing a clinic.
2. An employee has created a situation where he/she may harm himself/herself, his/her co-workers, and/or the public. In this type of situation, the Health Department may need to suspend this employee pending a hearing and a recommended disciplinary action such as termination of employment. The procedure outlined could be used to implement the suspension.

Adopted: September 13, 1985

Amended:



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RATIONAL ALLOCATION FORMULA (RAF)

The Board of Health hereby adopts a policy to distribute funds available for primary health care in an equitable manner.

The formula for distribution should reward good performance and penalize poor performance.

The formula for distribution should have as part of its criteria compliance with the performance standards patterned after the Federal Regulation.

The formula for distribution should include a process of evaluating the centers, ranking the centers according to their performance scores, and applying those rankings to an available fund of dollars.

The formula for distribution should be evaluated and updated on a regular basis.

Adopted:      March 24, 1981  
Amended:     September 3, 1986



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REIMBURSEMENT OF EXPENDITURE OF FUNDS FOR SENIOR POSITIONS IN THE  
HEALTH DEPARTMENT

The Cincinnati Board of Health will consider and approve, as necessary, reimbursement of reasonable expenditure of funds for travel and other expenses for the recruitment of applicants for senior management and professional positions in the Health Department as vacancies occur.

Adopted: February 27, 1971  
Amended: November 28, 1978  
November 27, 1984



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REIMBURSEMENT OF RELOCATION EXPENSES

Upon recommendation of the Commissioner of Health, the Board of Health may authorize the reimbursement of employees for all reasonable expenses incurred as a result of relocation under the following circumstances:

1. Reassignment either to or from a permanent work station located 40 or more miles from the Burnet and Melish headquarters of the Health Department when such work station is assigned and in accordance with City Council and Board of Health policies;
2. Hiring by the Department into a professional or senior managerial position which is filled as a result of a broad national recruitment effort.

Adopted: November 28, 1978

Amended: February 27, 1979

October 23, 1984



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STUDENT OBSERVATION OF THE CINCINNATI HEALTH DEPARTMENT

It is the policy of the Board of Health to encourage student observation of the activities of the Cincinnati Health Department.

Adopted: May 25, 1971  
Amended: April 22, 1986





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POLICY REGARDING BOARD OF HEALTH EQUITY CONCERNS FOR UNCLASSIFIED  
EMPLOYEES

Any unclassified senior staff employee who has concerns about equity in his/her position should submit a request through the Health Commissioner to the City Personnel Department for an equity study.

If, after 12 months, no action has been taken on the equity concerns submitted to the City Personnel Department, the unclassified member of senior staff has the option to appeal to the Board of Health. The Board of Health at that time could:

1. Resubmit the equity concerns to the City Personnel Office;
2. Initiate an equity study by an outside agency;
3. Take any appropriate action that the Board feels necessary to resolve the concerns.

Adopted: April 27, 1995  
Amended:



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POLICY FOR DELEGATION OF AUTHORITY TO THE HEALTH COMMISSIONER TO  
QUARANTINE AND ISOLATE

- I. Necessary Findings of Health Commissioner. In order for the provisions of this Policy to take effect, the Health Commissioner must make a finding that: (a) a threat to the public health exists; or, (b) the action is necessary to administer the provisions of sections 3707.04 to 3707.32 of the Revised Code; and (c) circumstances have rendered a meeting of the Board of Health to be impractical or impossible; or (d) delaying action until a meeting of the Board of Health would compromise the public health.
  
- II. Scope of Delegation. Upon the Health Commissioner making the necessary findings enumerated in Section I of this Policy, the provisions of this Policy shall become effective immediately. In such a case, the Health Commissioner is hereby delegated all the authority possessed by the Board of Health in enforcing the provisions of sections 3707.04 to 3707.32 of the Revised Code regarding quarantine and isolation. The Health Commissioner is hereby authorized to act on behalf of the Board of Health in these matters, and any actions taken by the Health Commissioner in accordance with this Policy shall be considered actions taken by the Board.
  
- III. Expiration/Renewal of Authority Granted by this Policy. The authority delegated to the Health Commissioner under this Policy shall continue until the earlier of: (a) a finding by the Health Commissioner that such delegation of authority is no longer necessary; or (b) the holding of a regular or special meeting of the Board of the Health wherein Board makes a determination whether to extend, modify, or suspend the delegation of authority.

Adopted: February 24, 2004

Amended:



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CITY CHARTER

Attached is a copy of Article VII, Section 11, of the Charter of the City of Cincinnati which discusses the Board of Health. On March 25, 1986, this Section of the Charter was approved to be included in the "Informational" Section of the Board of Health Policy Manual.

Adopted:        March 25, 1986

Amended:





RESOLUTION CONCERNING CIVIL RIGHTS ACT OF 1964

On March 25, 1986, the Board of Health approved including the attached Resolution in the "Information" section of the New Board of Health Policy Manual.

Adopted: March 25, 1986

Amended:



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ORDINANCE TO ACCEPT GIFTS UNDER \$2,500

On September 24, 1985, the Board of Health assigned to the Information Section of the Board of Health Policy Manual a copy of the Ordinance permitting the Health Department to accept grants, gifts and donations less than \$2,500 without an Ordinance from City Council.

Adopted: September 24, 1985

Amended:



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SUNSHINE LAW

It shall be the policy of the Board of Health to abide by Section 121.22 of the Ohio Revised Code, "Meetings of Governmental Bodies to be Public; Exceptions", known as the "Sunshine Law."

Approved by the Board for inclusion in the "Information" Section: May 22, 1984