



Highland Community College Board of Trustees
Illinois Community College District #519
Special Meeting
August 15, 2018 – 4:00 p.m.

Highland Community College
Student/Conference Center, Room H-206
2998 West Pearl City Road, Freeport, Illinois

- I. CALL TO ORDER/ROLL CALL**
- II. PUBLIC COMMENTS**
- III. MAIN MOTIONS (ACTION)**
 - A. Part-time Instructor Rates (Page 1)
 - B. Approval of Service Agreement Between Highland Community College and FHN Family Counseling Center for the Provision of Mental Health Services (Page 2)
- IV. CLOSED SESSION**
 - A. Appointment, Employment, Compensation, Discipline, Performance, or Dismissal of Specific Employees of the Public Body or Legal Counsel for the Public Body, Including Hearing Testimony on a Complaint Lodged Against an Employee of the Public Body or Against Legal Counsel for the Public Body to Determine its Validity
- V. OLD BUSINESS**
- VI. NEW BUSINESS**
- VII. ADJOURN**

**AGENDA ITEM #III-A
AUGUST 15, 2018
HIGHLAND COMMUNITY COLLEGE BOARD**

PART-TIME INSTRUCTOR RATES

RECOMMENDATION OF THE PRESIDENT: That the Board of Trustees approves the following part-time instructor rates effective starting in the Fall 2018 semester.

Part-time Instructors (per credit hour):

| | <u>Current Rate</u> | <u>2% Increase</u> | <u>Proposed New Rate</u> |
|---------------|---------------------|--------------------|--------------------------|
| Less than MA: | \$464.40 | \$ 9.29 | \$473.69 |
| MA (or more): | \$520.91 | \$10.42 | \$531.33 |

A merit increment of \$15 per contact hour over part-time rate is available when the following qualifications are met:

- a) Recommendation of dean.
- b) Four or more previous semesters of service.
- c) A satisfactory evaluation is on file.

BACKGROUND: This increase is consistent with the 2% increase recommended for administrative, professional, and classified non-union staff that was approved by the Board at their regular meeting on July 17, 2018.

BOARD ACTION: _____

**AGENDA ITEM #III-B
AUGUST 15, 2018
HIGHLAND COMMUNITY COLLEGE**

**APPROVAL OF SERVICE AGREEMENT BETWEEN
HIGHLAND COMMUNITY COLLEGE AND FHN FAMILY COUNSELING CENTER
FOR THE PROVISION OF MENTAL HEALTH SERVICES**

RECOMMENDATION OF THE PRESIDENT: It is recommended that the Board of Trustees approves the agreement between Highland Community College and FHN Family Counseling Center for the provision of student mental health assessments, crisis counseling, consultation and training at a rate of \$90.00/hour for a minimum of five hours per week and a maximum of 10 hours per week while classes are in session during FY19.

BACKGROUND: Highland Community College developed an agreement with FHN Family Counseling for the 2009 – 2010 academic year following a request for proposals (RFP) process for the provision of mental health services on the Highland campus. This agreement allows us to provide crisis intervention and assessment services for students and increases our capacity for consultation and training related to student mental health concerns.

The attached service provision agreement stipulates that a qualified mental health professional (QMHP) will be located on Highland’s campus five to ten hours per week while classes are in session for the fall 2018 and spring 2019 semesters. This agreement has been incorporated into the College’s risk management plan. Release and informed consent forms, in addition to an HCC referral form, will allow the QMHP to execute services and communicate with appropriate Highland staff regarding concerns, attendance at appointments, and student progress while remaining compliant with the FERPA and HIPPA. The QMHP assigned to Highland also participates as a member of the Behavioral Intervention Team in conducting threat assessment.

This agreement will be reviewed at the end of the Spring 2019 semester.

BOARD ACTION: _____



SERVICE PROVISION AGREEMENT

Between FHN FAMILY COUNSELING CENTER and HIGHLAND COMMUNITY COLLEGE

Highland Community College ("HCC") and FHN Family Counseling Center ("Center") enter into this Agreement for the Center to provide: (a) mental health assessment services, (b) crisis intervention, and (c) faculty/staff training on the HCC Campus. This Agreement shall commence as of August 1, 2018 and expire as of September 30, 2019.

HCC WILL:

- Pay Ninety Dollars (\$90.00) per hour for five (5) hours per week up to but not to exceed ten (10) hours per week for the services of a Qualified Mental Health Professional ("QMHP"); however, in the event of a Catastrophic Situation (as defined below), the hours and reimbursement for the hours may exceed the ten (10) hours per week;
- Provide a calendar of the college semester including days classes are in session and holidays;
- Provide the QMHP access to an HCC E-mail Account with electronic calendar, private telephone, office space, computer, and a locked filing cabinet during the hours the QMHP is present on campus;
- Coordinate and schedule individual student meetings for the Center staff during work hours on HCC's Campus;
- Provide access to a copier;
- Provide a written waiver form following FERPA Guidelines that allows HCC to receive risk, assessment, and progress reports from the Center; and
- Meet mid-contract with the Center's administrators to discuss the Agreement and service provision for possible improvement revisions.

CENTER WILL:

- Provide a qualified counselor to serve as a confidential advisor for the purposes of responding to confidential student reports of sexual assault, harassment and misconduct.
- Provide a qualified, consistent (barring turnover) staff person who has knowledge of college student issues and stressors to be available to HCC Students, Staff and Faculty, and work to develop relationships within the College Community;
- Provide a schedule of work hours during the time classes are scheduled;
- Provide (in the following priority order) individual mental health and crisis assessments for HCC Students; consult with members of the HCC Faculty and Staff for the purposes of discussing concerns about HCC's Students; participate in Behavioral Intervention Team meetings and provide consultation to the group; plan, develop and deliver trainings and informational in-service sessions for faculty, staff and HCC Students as determined in collaboration with the HCC Behavioral Intervention Team Members and Administrators;
- Refer students for crisis intervention and referral services;
- Refer confidential sexual assault reports to the VOICES counselor/Confidential Advisor. Other reports of sexual assault will be provided to College's Title IX Officer;

FHN FAMILY COUNSELING CENTER - STEPHENSON COUNTY

421 W. Exchange Street, Freeport, Illinois 61032

Phone: 815-599-7300 Toll Free: 866-417-0537 Fax: 815-599-7394

Website: www.fhn.org

- Inform students of the options for obtaining mental health services in the local area and make available information about local service providers including the Center. Explain payment options as needed upon referral to improve access to services;
- Obtain a written Release in the form attached as Exhibit "A", in accordance with HIPPA Guidelines, and the Illinois Mental Health and Confidentiality Act that allows the Center to communicate with HCC about a student's progress or referral;
- Prior to providing individual mental health and crisis assessments for HCC Students, obtain an Informed Consent;
 - NOTE: The Illinois Statues allow providers to:
 - Provide eight (8) ninety (90) minute outpatient counseling sessions to any minor student, aged 12 through 17, at the Center without parental or guardian consent at no cost to the minor student and/or the minor student's parents or guardian, and without disclosure to the minor student's parents or guardian pursuant to 405 ILCS 5/3-501, unless consented to by the minor student;
 - Outpatient Application for Minors 12 and over will be completed by the minor and provider, and a copy provided to the individual and Operations Leader at Center.
- Purchase and maintain the malpractice insurance coverage required to provide these services;
- Meet mid-contract with HCC administrators to discuss the agreement and service provision for possible improvement revisions;
- Act as an immediate responder to provide mental health services on campus in the event that HCC would experience a catastrophic situation affecting the campus community. Catastrophic Situation shall be defined as: Emergency or Disaster Response ("Catastrophic Situation") ; however, in such Catastrophic Situation, FHN's disaster protocol and plan ("FHN's Disaster Plan") would take precedence over HCC's disaster protocol and plan, and Center's employees would be required to follow FHN's Disaster Plan. In the event a Catastrophic Situation would occur, the Center cannot guaranty that the responder(s) would be the same consistent, individual providing services to HCC; and
- Consult with HCC administrators to assist in the development of an emergency response plan for the provision of mental health services should HCC experience a catastrophic event. Provide assistance in the coordination of such services with other providers should an event take place.

OWNERSHIP OF MEDICAL RECORDS

HCC and Center agree as follows:

- a. Any records documenting interventions performed by the Center's Staff on the HCC Campus shall be owned jointly by HCC and the Center. FHN Family Counseling will maintain electronic records for a period of seven (7) years with Center's QMHP assigned to Highland Community College having access to the records at all times; and
- b. In the event a patient is referred to the Center for further treatment, the records shall be owned and maintained by the Center for a period of seven (7) years at Center's facility. HCC will be permitted access to these records provided the appropriate Release has been signed by the patient allowing HCC to have access to the records.

INVOICING AND PAYMENT FOR SERVICES

HCC will be invoiced a minimum of quarterly including hours worked and a general description of services provided. Invoices will be sent to the following individual at the following address: Highland Community College, 2998 West Pearl City Road, Freeport, IL 61032. Services shall be paid for by HCC to Center within thirty (30) days of invoicing.

NOTICES

Notices required herein shall be considered effective when delivered in person or when sent by United States Mail, postage prepaid, return receipt requested, and addressed to:

HCC:

Highland Community College
Attention: Vice President of Student Development and Support Services
2998 W. Pearl City Road
Freeport, Illinois 61032

CENTER:

FHN Family Counseling Center
Attention: Executive Director of Behavioral Health
421 W. Exchange Street
Freeport, Illinois 61032

GOVERNING LAW

This Agreement has been executed and delivered in, and shall be interpreted, construed and enforced pursuant to and in accordance with the internal laws of the State of Illinois without regard to its choice of law rules. Stephenson County, Illinois, shall be the sole and exclusive venue for any proceeding as between the parties in connection with this Agreement.


INDEMNIFICATION

HCC and Center agree to indemnify and hold harmless each other, and their respective employees and agents, against any and all liability, losses or damages or any expenses whatsoever as a result of claims, demands, damages, costs or judgments against HCC or Center that may arise in connection with the terms and conditions of this Agreement.

HIGHLAND COMMUNITY COLLEGE

BY: _____
Print Name: Tim Hood
As: President
Date: _____

FHN FAMILY COUNSELING CENTER

BY:  _____
Print Name: Gabriel Gonzalez
As: Executive Director of Behavioral Health
Date: 7/20/18



FHN FAMILY COUNSELING CENTER

421 W. Exchange Street
Freeport, Illinois 61032

300 Summit
Galena, Illinois 61036

Authorization to Release/Obtain Protected Health Information

Client Name: _____ Last _____ First _____ M.I. _____ DOB: ____/____/____

Phone #: _____

I hereby authorize FHN Family Counseling Center to **RELEASE** information to:

I hereby authorize FHN Family Counseling Center to **OBTAIN** information from:

| |
|-------------------|
| Individual: |
| Organization: |
| Street Address: |
| City: State: ZIP: |
| Phone #: Fax #: |

| |
|-------------------|
| Individual: |
| Organization: |
| Street Address: |
| City: State: ZIP: |
| Phone #: Fax #: |

INFORMATION TO BE RELEASED/RECEIVED:

- Psychosocial history
- Mental Health Assessment
- Attendance
- Other (specify) _____
- Psychiatric evaluation
- Treatment plan
- Recommendations
- Progress Notes
- Discharge summary
- Psychological evaluation
- Medications

CONCERNING THE CARE OF THE ABOVE PATIENT FROM DATES _____ TO _____

RELEASE OF HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of Highly Confidential Information listed below, I specifically authorize the use and/or disclosure of the category of Highly Confidential Information indicated next to the box:
(Please check all that apply—leaving a box unchecked may result in no information being disclosed for any purpose).

- Mental Illness or Developmental Disability
- Genetic Testing
- Substance (I.E., Alcohol or Drug) Abuse
- HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or recorded, regardless of whether the results of such tests were positive or negative)
- Abuse of an Adult with a Disability
- Sexual Assault
- Sexually Transmitted Diseases (STD's)
- Child Abuse and Neglect

PURPOSE FOR NEED OF DISCLOSURE: (CHECK ALL APPLICABLE CATEGORIES)

- Continuing Medical Care
- Moving to a new location
- Other (specify): _____
- Insurance Eligibility/Benefits
- Changing Physicians [Second Opinion, Specialist, Other]
- Personal
- Legal

I may inspect and obtain photocopies of the records disclosed. Photocopies of this authorization will be considered as valid as the original.

This authorization expires on the following calendar date ____/____/____. **(NOT TO EXCEED ONE YEAR).**

This authorization may be revoked by me at any time except to the extent that action has been taken based on my signed release prior to the revocation request.

If I refuse to sign this authorization, my records shall not be released. No other known consequence shall result if I refuse to sign. I waive and hold FHN Family Counseling Center harmless from any liability resulting from the release of the above-authorized information.

Authorization to Release/Obtain Protected Health Information

I have reviewed the requested information and agree that it may be released _____
Therapist Signature Date

I have reviewed the requested information and believe it should NOT be released _____
Therapist Signature Date

Client Signature: _____ Date: ____/____/____

Parent/Guardian Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____

Revocation Signature: _____ Date: ____/____/____

SPECIAL REQUIREMENTS APPLYING TO MINORS ONLY

The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof:

- The parent or guardian of a recipient who is under 12 years of age;
- The recipient if he is 12 years of age or older;
- The parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying the access. The parent or guardian who is denied access by either the recipient or the therapist may petition a court for access to the record. Nothing in this paragraph is intended to prohibit the parent or guardian of a recipient who is at least 12 but under 18 years from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed, including medication, if any.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse.

© 2001 FHN Family Counseling Center, 421 W. Exchange Street, Freeport, IL 61032 (815) 599-7300; fax (815) 599-7394