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DAVID E. JANSSEN
Chief Administrative Officer

Board of Supervisors
GLORIA MOLINA
First District

YVONNE B. BURKE
Second District

ZEV YAROSLAVSKY
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

February 17, 2006

To: Mayor Michael D. Antonovich
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

From: David E. Janssen
Chief Administrative Officer

MEMORANDUM OF UNDERSTANDING BETWEEN THE DEPARTMENT OF HEALTH SERVICES AND THE SEPARATE DEPARTMENT OF PUBLIC HEALTH AND RELATED ISSUES (ITEM NO. S-1, AGENDA OF FEBRUARY 28, 2006)

Item S-1 on your Board's February 28, 2006 agenda is the discussion of the planned separation of Public Health from the Department of Health Services (DHS) and consideration of the related ordinance changes. This issue was originally placed on your Board's December 13, 2005 agenda and was continued to a later date, so that my office could work with DHS and Public Health (PH) staff to complete the draft Memorandum of Understanding (MOU) between the departments, and review the drafts with the affected Commissions.

Clarification on Organizational Changes

First, we wanted to clarify an issue raised at your December 13, 2005 meeting regarding any changes in the reporting relationships for the staff at the Public Heath Clinics, Health Centers and the Comprehensive Health Centers. If the Board approves the separate Department of Public Health (DPH), there will be no change in those reporting relationships.

Attachment I is the DHS organization chart from the 2005-06 Proposed Budget, which shows the reporting relationship of four of the five budgets which are proposed as part of DPH, specifically Public Health Services (PH), Office of AIDS Programs and Policy (OAPP), Alcohol and Drug Programs Administration (ADPA), and Children's Medical Services (CMS). These units appear in the center of Attachment 1 and report to the Director of Public Health. This reporting relationship will remain the same in the new DPH.

What will change is that the Director of Public Health will report directly to your Board rather than to the Director of Health Services.

Attachment 2 is the organization chart which shows the reporting relationship for the units within the PH budget. The Public Health Clinics are part of the Service Planning Areas (SPAs), which report to the Public Health Medical Director. That reporting structure will not change if the separate DPH is established. Attachment 3 is a listing of the existing Public Health Clinics and the Health Centers and Comprehensive Health Centers, which are part of the hospital networks shown on Attachment 1, a different reporting structure from the Public Health Clinics. The hospital networks report to the DHS Chief Network Officer and that will not change if the separate DPH is established.

Attachment 4 is the organization chart for the Antelope Valley Area/High Desert Health System, now included in the San Fernando Valley Area. Attachment 4 shows the Director of the Antelope Valley Rehabilitation Centers (AVRCs) as reporting to the Administrator, High Desert Health System (HDHS). That reporting relationship will change if the separate DPH is established, because, under the new DPH, the Director of AVRCs will report to the Director of ADPA. However, the staff reporting structure within AVRCs will not change.

Draft MOU between DHS and DPH

As instructed, my staff has worked with DHS, PH and County Counsel staff to prepare the attached draft MOU between DHS and DPH (Attachment 5). The MOU describes programs where DHS and DPH share responsibilities or where the effectiveness of their separate responsibilities are dependent on the effectiveness of the other department's programs.

In response to your Board's instruction to provide for on-going collaborative efforts, the MOU also commits DHS and DPH to establish a joint working group consisting of existing staff, as selected by the respective Directors, to meet at least quarterly to monitor the program areas in the MOU and identify others, on an on-going basis, to ensure that interdepartmental efficiencies and service improvements in personal and public health are regularly achieved. The working group will discuss critical changes in departmental needs, mandates, personnel, and financial resources affecting the other department, so that this information can be provided to the other department, on a timely basis. The MOU indicates that the working group will seek input from stakeholder groups and subject matter experts in meeting their responsibilities.

The MOU includes two appendices, one for Program Services and the other for Administrative Services, with discrete sections in each. This structure of the MOU was used in order to make it less cumbersome for DHS and DPH to amend or add to the MOU as needed in order to keep the MOU current in terms of the roles and responsibilities of each department.

The Program Services Appendix currently includes 15 sections, including client services, such as prevention, tuberculosis, sexually transmitted diseases, HIV/AIDS, immunization, substance abuse, homeless assistance, family planning, Women's Health, and California Children's Services, as well as areas where DHS and DPH provide services to one another, such as radiology, laboratory, oral health, pharmacy, and health services information.

The Administrative Services Appendix currently includes 8 sections, including information technology and data sharing, human resources, employee health services, facilities and space management, library services, training programs, jointly administered agreements, and membership on Countywide coalitions, committees and commissions.

In areas where a cost allocation or fee-for-service methodology is to be developed, the MOU indicates that my office will work with DHS and DPH to develop that methodology and recommend to the Board the necessary adjustments to the DHS and DPH budgets. We expect those actions to be completed no later than June 30, 2006, so the adjustments can be incorporated into the 2006-07 Adopted Budget for each department.

The MOU also addresses an issue raised by several individuals regarding the impact of creating the separate department on the sharing of information between DHS and DPH. The departments and my staff will work with County Counsel to ensure that information currently shared between the departments can continue to be shared, and DPH continues to be in compliance with the Health Information Portability and Accountability Act (HIPAA) requirements. The departments will also work with County Counsel to review current barriers to the sharing of information between DHS and DPH, which exist regardless of whether DHS and DPH remain as one department or separate into two, so that action steps can be developed to remove those barriers.

Finally, in response to comments regarding the need for dispute resolution provisions in the MOU, such provisions are generally not included in MOUs between County departments and, therefore, they are not included here. As with other disagreements between County departments, my office will continue to provide assistance to DHS and DPH in resolving any issues, as needed, including bringing policy recommendations to your Board when that may be appropriate.

Draft MOU between DHS, DPH and DMH for AVRCs

Staff from my office, PH, Department of Mental Health (DMH) and DHS have met to discuss the proposed transfer of AVRCs to DPH from DHS, and there is support for including AVRCs in DPH, if the new department is established. Although we have encountered delays in completing the draft MOU, there do not appear to be areas of disagreement which would affect your Board's consideration of this proposal. Should your Board establish the new department, we anticipate completing the MOU by March 31, 2006.

The operational issues which will be addressed in the MOU include: 1) support currently provided by HDHS and Olive View Medical Center, which would be provided by DPH, including senior management support on a 24/7 basis; financial administration; telephone systems; information systems equipment, software and support; pharmacy systems; and plant maintenance; 2) Human Resources support, currently provided by DHS central administration, which would be handled by DPH; 3) support currently provided by HDHS, which would continue to be provided by HDHS, including laboratory, radiology and urgent care; and 4) support already assumed within the AVRCs budget and operations, which will remain there, including supplies and purchasing, custodial services, and safety police.

Programmatic areas included in the MOU will relate to the continued collaborative efforts between DHS, PH and DMH, related to program services for patients with multiple co-occurring health, mental health and substance abuse problems. The departments intend to move forward with developing the MOU to address the shared responsibilities in these program areas, regardless of whether the new department is established.

Draft MOU between DHS, DPH and DMH for Psychiatric Services

As mentioned in our earlier report, we will prepare the MOU between DHS, DPH and DMH as a separate document from the MOU between DHS and DPH discussed above, and we will continue with this process regardless of whether the separate department is established. We intend to use a format similar to the MOU for DHS and DPH in Attachment 5, which is significantly more detailed than the current MOU.

We are in the process of scheduling meetings, beginning in March, with DHS, PH and DMH staff to discuss the roles and responsibilities, including financing, of those departments in serving persons in need of mental health services. Our target for completing the MOU, including execution by the departments, is August 30, 2006. Our timeframe will include review by the Mental Health Commission members.

Comments from Commissions

As instructed by your Board, we met with the Public Health, Mental Health and Hospitals and Health Care Delivery Commissions to review the draft MOU between DHS and DPH. Following that review, we received written comments from the Public Health Commission (Attachment 6) and from the Hospitals and Health Care Delivery Commission (Attachment 7), which are provided for your reference. Since we have not yet drafted the MOU with DMH, we did not receive written comments from the Mental Health Commission; however, we did receive informal comments that were supportive of our plan to develop the MOU using a detailed format similar to Attachment 5, which will clearly define the duties and financing components of the departments.

Revised Timeline

We have attached an updated timeline for implementation of all actions to create the separate Department of Public Health by June 30, 2006 (Attachment 8). The implementation timeline now includes the proposed development and execution of the MOU for DHS, DPH and DMH for the AVRCs by March 31, 2006, the execution and development of the MOU between DHS, DPH and DMH for psychiatric services by August 30, 2006.

In order to keep your Board informed on our progress in implementing these action steps, we anticipate providing a copy of the MOU for the AVRCs by April 2006 and a copy of the MOU between DHS, DPH and DMH by September 2006.

If you have questions or need additional information, please contact me or your staff may contact Sheila Shima of my office at (213) 974-1160.

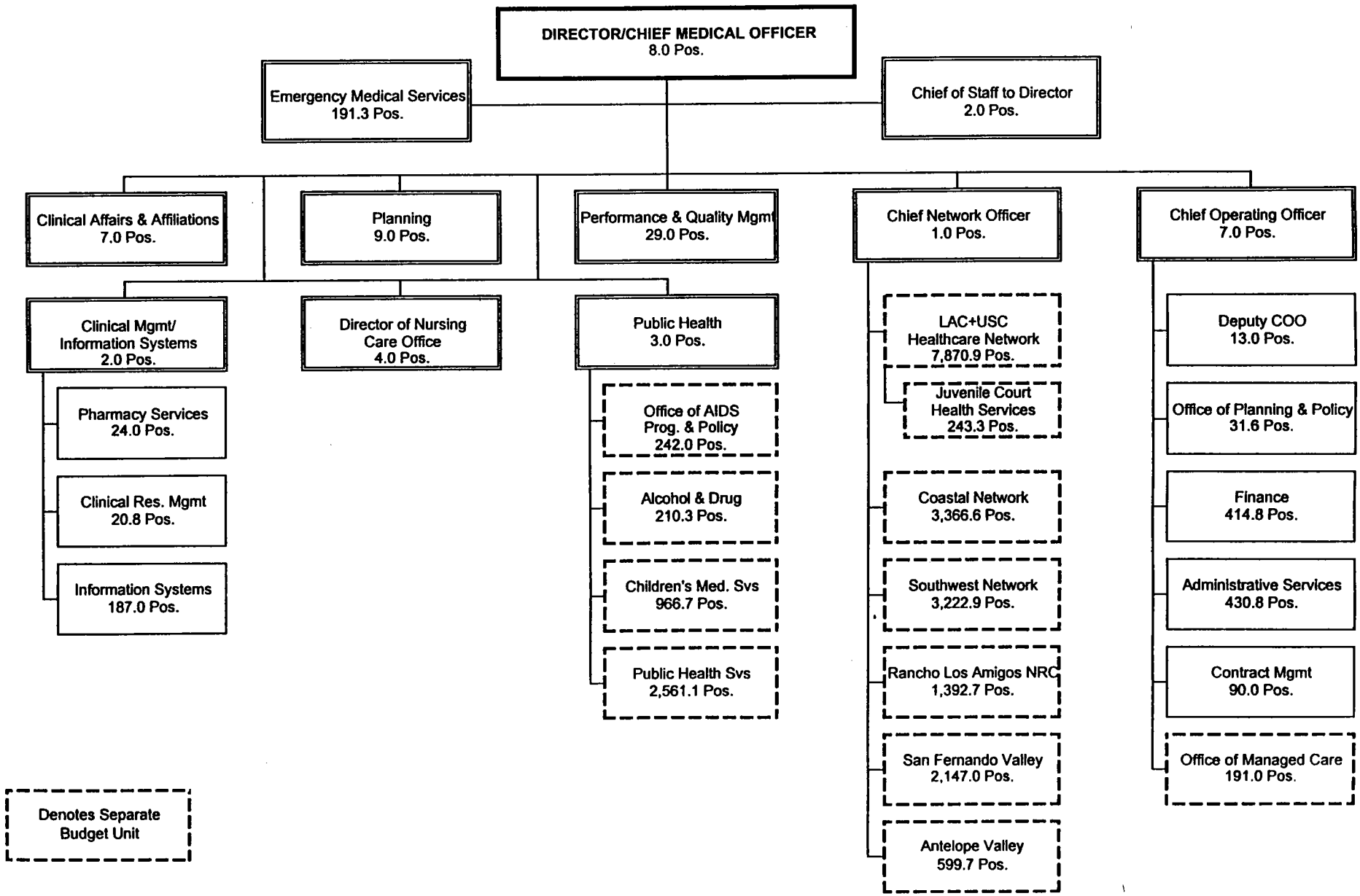
DEJ:DIL
SAS:bjs

Attachments

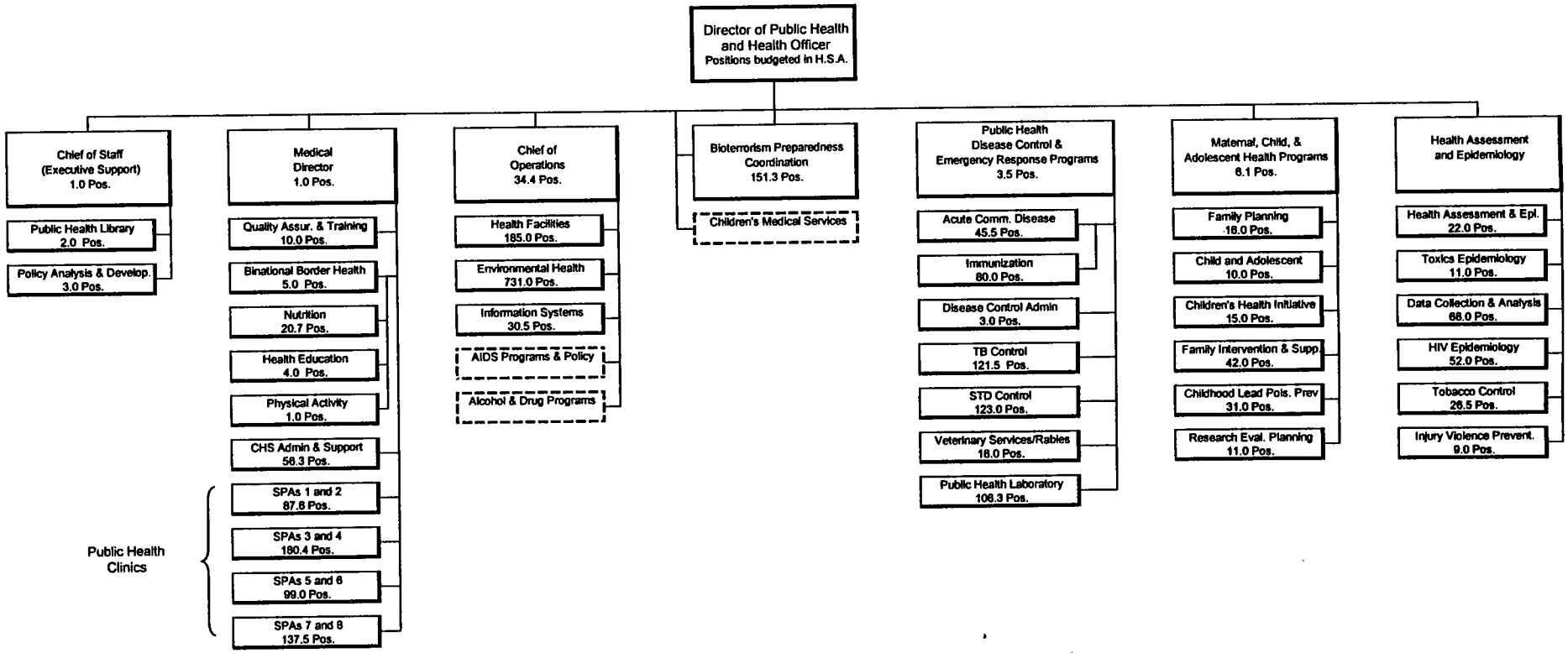
c: Executive Officer, Board of Supervisors
County Counsel
Auditor-Controller
Acting Director of Health Services
Director of Mental Health
Director of Personnel
Chair, Hospitals and Health Care Delivery Commission
Chair, Mental Health Commission
Chair, Public Health Commission

Health Services

2005-06 Proposed Budget Total Positions: 24,489.5



Health Services - Public Health
2005-06 Proposed Budget Total Positions: 2,561.1



Denotes separate Budget Unit

DEPARTMENT OF HEALTH SERVICES
LISTING OF OUTPATIENT FACILITIES BY LOCATION
FISCAL YEAR 2005-06

Personal Health Service (PHS)

Comprehensive Health Centers / Health Centers

LAC+USC Healthcare Network
- H. Claude Hudson CHC
- El Monte CHC
- La Puente HC

Coastal Network
- Long Beach CHC
- Bellflower HC
- Wilmington HC

Southwest Network
- Hubert H. Humphrey CHC
- Dollarhide HC

Valley Care Network

San Fernando Valley
- Mid-Valley CHC
- Glendale HC
- San Fernando HC
- Vaughn Street School Based Health Center

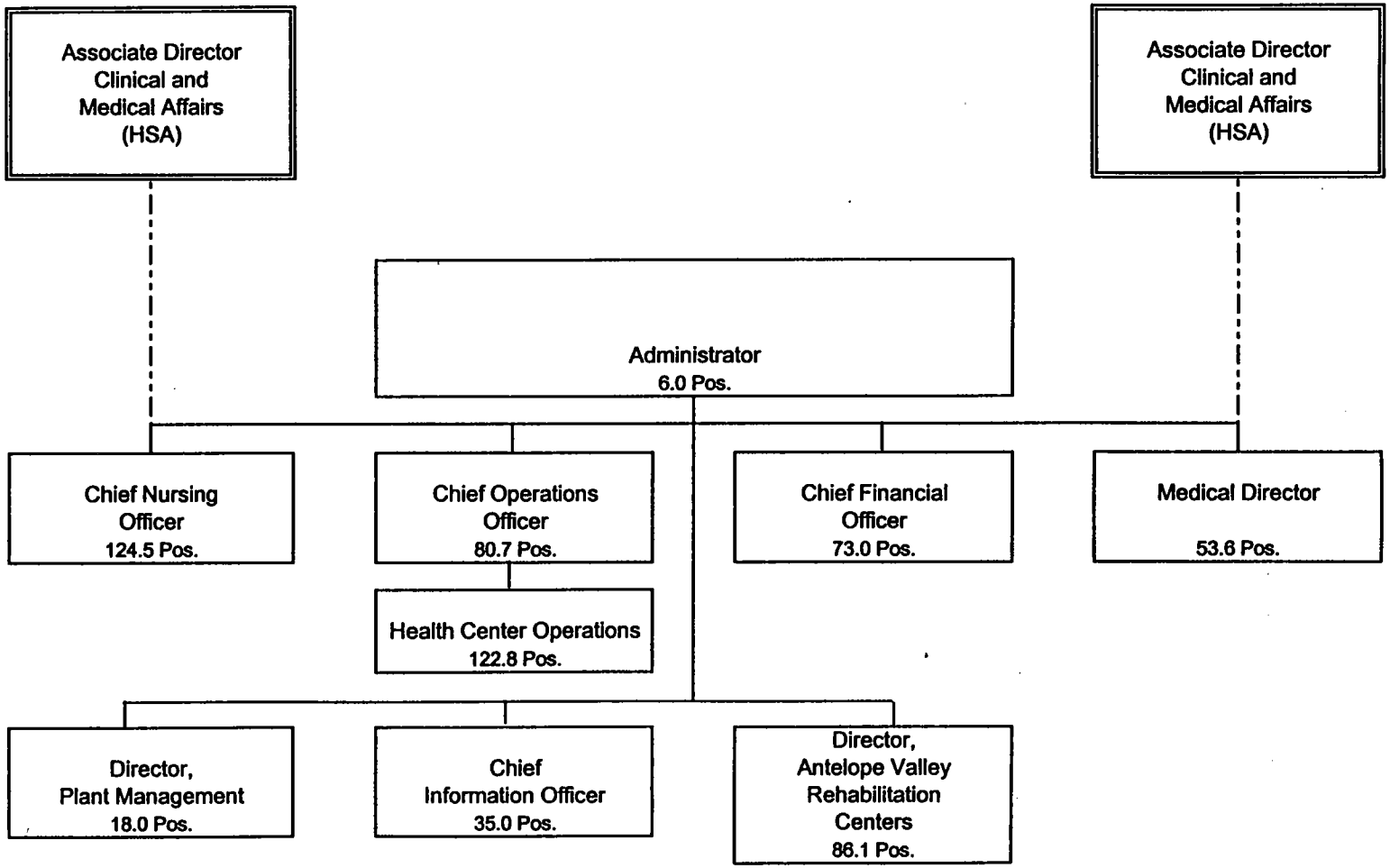
Antelope Valley Area
- High Desert Health System
- Antelope Valley HC
- Littlerock/Lake LA HC
- South Antelope Valley HC
- Acton & Warm Springs Rehabilitation Center

Public Health Programs & Services (PHP&S)

Public Health Centers

- Antelope Valley HC
- Central HC
- Curtis R. Tucker HC
- Glendale HC
- Hollywood-Wilshire HC
- Monrovia HC
- North Hollywood HC
- Pacoima HC
- Pomona HC
- Ruth Temple HC
- Simms/Mann Health and Wellness Center
- South HC
- Torrance HC
- Whittier HC

Health Services - Antelope Valley Cluster
2005-06 Proposed Budget Total Positions: 599.7



MEMORANDUM OF UNDERSTANDING BETWEEN THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES AND THE LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH

This Memorandum of Understanding ("MOU") is made and entered into this ___ day of _____, 2006, by and between the Los Angeles County Department of Health Services and the Los Angeles County Department of Public Health.

WHEREAS, under State, federal and local law, the Department of Health Services operates a network of hospitals, comprehensive health centers and health centers, and provides population-based public health services to the citizens of Los Angeles County; and

WHEREAS, by action of the Board of Supervisors on _____, 2006, the Los Angeles County Department of Health Services and its functions were divided into two separate departments named the Department of Health Services (hereinafter referred to as DHS) and the Department of Public Health (hereinafter referred to as DPH);

WHEREAS, DHS is charged with providing a variety of inpatient and outpatient services through its network of hospitals, comprehensive health centers, and health centers, as well as a number of programs, including the Community Health Plan and the Public Private Partnership program;

WHEREAS, DPH is charged with meeting the County's public health responsibilities and duties through its programs, network of public health centers, and contracted services;

WHEREAS, it is the intent of the Board of Supervisors and each department to ensure a smooth transition from the one entity into the two new entities;

WHEREAS, it is the intent of DHS and DPH to insure that the services offered by both departments are coordinated and that the principles of prevention and health promotion are integrated into DHS' clinical services; and

WHEREAS, it is the intent of DHS and DPH to set forth their respective rights and responsibilities concerning fiscal and operational issues arising out of this division of duties; and

WHEREAS, this MOU and its appendices are intended to describe programs where DHS and DPH share responsibilities or where the effectiveness of their discrete responsibilities are dependent on the effectiveness of the other department's programs and will be improved by the continued and enhanced

collaboration by staff in both departments; and

WHEREAS, this MOU is not intended to be a comprehensive listing of DHS and DPH programs where shared responsibility and/or interdependency does not exist or is not appropriate.

NOW, THEREFORE, the parties hereto agree as follows:

1. **TERM AND TERMINATION**: The term of this Memorandum of Understanding (MOU) shall be from _____, 2006, and shall continue through June 30, 2006. This MOU shall be automatically renewed for successive county fiscal year periods thereafter. This MOU may be modified or amended by the written, mutual consent of both parties. All amendments or modifications shall be documented in writing.

2. **SHARED RESPONSIBILITIES**: Both DHS and DPH agree to:

   A. Work to ensure a smooth transition and to realize the mutual benefit of operating through two separate organizational structures.

   B. Maintain frequent and consistent communication throughout the transition period and ongoing to ensure the needs and interests of each department are appropriately articulated and represented.

   C. Inform each other of critical changes in departmental needs, mandates, personnel, and financial resources that may impact the other department.

   D. Work together on areas of joint interest to facilitate and enhance program planning and implementation, such as health promotion and prevention of disease, control and management of chronic disease, grant applications and other funding opportunities, and increasing access to high quality health services.

3. **ENTIRE AGREEMENT**: This MOU and all appendices and exhibits thereto shall constitute the final, complete and exclusive statement of the terms of the agreement between DHS and DPH pertaining to the subject matter in this agreement and supersede all prior and contemporaneous understandings or agreements of the parties.

4. **MODIFICATION OF AGREEMENT**: This MOU may be supplemented, amended, or modified only by mutual agreement of the parties. No supplement, amendment or modification of this agreement shall be binding, unless it is in writing and signed by all parties.

IN WITNESS WHEREOF, the parties hereto have executed this Memorandum of Understanding as of this _____ day of _____, 2006.

Department of Health Services

_____

Department of Public Health

_____

APPROVED AS TO FORM

RAYMOND G. FORTNER, JR.
County Counsel

By_____
SHARON A. REICHMAN
Principal Deputy County Counsel

APPENDIX A. **PROGRAM SERVICES SCOPE OF WORK**

DHS and DPH shall establish a joint working group, with membership to be determined by the Directors of DHS and DPH, which will meet on a regular basis, but at least quarterly, to monitor the program areas set forth in the attached Appendices and identify others, on an on-going basis, to ensure that interdepartmental efficiencies and service improvements in personal health and public health services are regularly achieved. This working group shall be responsible for determining, on behalf of their respective Directors, where program collaboration has been successfully implemented and can be replicated in other program areas, or where barriers to efficiencies or service improvements may exist and where workable solutions must be developed to eliminate or mitigate those barriers.

This working group also shall have on-going responsibility for determining other program areas which should be incorporated into this MOU to further enhance interdepartmental collaboration. In addition, the working group shall discuss critical changes in departmental needs, mandates, personnel, and financial resources affecting the other department, so that this information can be provided, on a timely basis, to the other department. The joint working group shall, on a regular basis, seek input from stakeholder groups or experts in their respective program areas, as appropriate, in meeting these responsibilities. Recommendations of this joint working group shall be forwarded to the Directors of DHS and DPH for review and appropriate actions.

The provisions of this MOU shall be supplemented, amended or modified, on a regular basis, as provided for under the terms of this MOU, so that the roles and responsibilities of DHS and DPH in administering the programs described herein are current, are clearly delineated and can be communicated on a consistent basis to the appropriate DHS and DPH staff.

Appendix A.1 **Oral Health**

If requested by DHS, DPH will continue to provide contract monitoring, technical assistance, and professional guidance for dental services provided by DHS and its community partners. By June 30, 2006, DHS and DPH will negotiate specific frequencies of requested services and specific reporting mechanisms to implement this section, as needed. DPH projects that this service to DHS will require no more than 0.5 Full-Time Equivalent of dental professional time.

In addition, if requested by DHS, DPH agrees to recommend and provide technical assistance to DHS oral health operations on current dentistry practice and prevention standards, as promulgated by the Centers for Disease Control and Prevention, the California Dental Board, the California Dental Association, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and the California Association of Dental Plans.

Appendix A.2 **Radiology Services**

DHS agrees to allow DPH to access its contract for registry staff for radiology services. Costs associated with DPH use of registry staff under these contracts shall be invoiced to DPH, and reconciliation and payment of invoiced costs will be a DPH responsibility. In addition, DHS and DPH agree to work together to ensure that digital radiology systems will be compatible, to ensure seamless care for patients.

Appendix A.3 **Pharmacy Services**

DHS agrees to continue to provide pharmacy services to the public health centers, through the LAC+USC Medical Center Pharmacy, until DPH secures its own clinic dispensing permits for the public health centers as part of its plan to develop a Public Health Pharmacy. DPH agrees to continue to fund the existing six Public Health positions at the LAC+USC Medical Center Pharmacy to support the public health center dispensing services, until DPH secures its own permits. In addition, DPH will continue to pay for its own medication. It is expected that the transfer of responsibility to Public Health will occur no later than June 30, 2006, pending the State's approval of DPH's 340B application and license to dispense medication on-site.

Appendix A.4 **Laboratory Services**

DPH operates the Public Health Laboratory (PHL). PHL is certified as an approved local PHL and as an environmental testing lab by the California Department of Health Services. The PHL is also certified as a high complexity testing lab by the federal CLIA 88. Mandated services of PHL include services necessary for the various public health programs and consultations and reference services related to the prevention and control of human diseases (Title 17, section 1276).

To support the County Health Officer functions of prevention and control of diseases, the PHL conducts a variety of diagnostic and surveillance tests, which include, but are not limited to, testing for tuberculosis, HIV-1, syphilis, gonorrhea, Chlamydia, Hepatitis, West Nile, SARS and Influenza. Additionally, tests are provided to support epidemiologic and outbreak investigations of diseases such as botulism, salmonellosis, typhoid fever, *Escherichia coli* O157-H7, Norovirus, Hepatitis A and clearance testing to assure that food handlers and persons in critical occupations are free of communicable diseases.

DHS operates various laboratories conducting a variety of clinical diagnostic services.

Until June 30, 2006, both DHS and DPH agree to continue to provide laboratory testing services to each other as currently provided, as requested by the Departments. Appropriations to cover the cost of this testing are assumed in each departments' budget and no charges, other than any already charged, will be due to either department.

Effective July 1, 2006, based on budget adjustments determined by the Chief Administrative Office for the 2006-07 Adopted Budget, each department will reimburse the other for the laboratory services provided, as outlined below.

DPH agrees to provide the following services:

a. Diagnostic testing of specimens and/or samples collected from DHS hospitals and clinics, and transported to the Public Health Laboratory. The PHL fees for these tests shall be based on cost. The cost includes staff time, supplies and reagents, and pro-rated QA costs. DPH will compare its costs to Medi-Cal rates when developing its fee schedule. A list of fees will be provided to DHS. For eligible clients, DHS shall provide PHL with all information needed to bill Medi-Cal/Medicare.

b. Reference tests, which will be provided free of charge. A list of tests that the PHL provides at no cost is included as Exhibit I. This list will be updated as needed.

c. DHS facilities will arrange the required collection and timely transport of the specimens/samples to the PHL. The PHL will receive the noted specimens/samples via contract courier during mutually agreed scheduled days and time. The specimens will be labeled in a standardized format and the PHL test requisition completed according to instructions.

d. Reporting out of results will be made to a designated DHS individual from the facility collecting the specimen/sample by a mutually agreed-upon method. DPH will provide DHS facilities with summary data upon request.

DHS Clinical Laboratories at County hospitals provide testing for Public Health Centers. These public health centers include Antelope Valley, Glendale, North Hollywood, Pacoima, Monrovia, Pomona, Central, Hollywood-Wilshire, Burke, South, Ruth Temple, Whittier, Torrance, and Curtis Tucker.

DHS agrees to provide the following services:

a. Diagnostic testing of specimens and/or samples collected from DPH public health centers and transported to the appropriate DHS Clinical Laboratory. DPH will be charged for this service at DHS published rates based on cost. DHS will compare costs to Medi-Cal rates when developing its fee schedule;

b. DPH facilities will arrange the required collection and timely transport of the specimens/samples to the appropriate DHS Clinical Laboratory. The DHS Lab will receive the noted specimens/samples via contract courier during mutually agreed scheduled days and time. The specimens will be labeled in a standardized format and the DHS test requisition completed according to instructions; and

c. Reporting out of results will be made to a designated DPH individual from the facility collecting the specimen/sample by a mutually agreed-upon method. DHS will provide summary data to DPH facilities upon request.

If either party chooses to use an outside vendor for laboratory services rather than the arrangement outlined in this MOU, advance notice of 60 days must be given so the affected departments can plan accordingly.

Appendix A.5 **Preventive Services**

Preventive health services include primary prevention (immunization, and health promotion), secondary prevention (screening for early detection and treatment of disease) and tertiary prevention (effective treatment to minimize disability).

DHS facilities serve many County residents who may not be seen in other clinical or preventive health settings. DHS clinical interventions provide the opportunity to incorporate essential and/or important preventive health strategies. DPH provides expertise and specific assistance in the sphere of communicable disease control and prevention (TB, STD, HIV/AIDS, and acute communicable diseases), immunization, substance abuse (alcohol, drugs and tobacco), women's health, and other areas.

Joint involvement by DHS and DPH will strengthen preventive services, and strong preventive health approaches are life-saving and cost-saving measures vital to healthy patients and communities. DHS and DPH agree to maintain joint involvement regarding prevention needs and opportunities in DHS facilities and operations to include mechanisms for joint planning, communication, training, implementation, consultation and technical assistance.

DHS and DPH agree to:

a. Continue to work together to implement the Integration Plan developed in 2003 and updated in 2005, included as Exhibit II, which addresses clinical prevention strategies and shared information. Both departments will continue to co-chair and participate on an integration task force to monitor and update this plan and to expand to include new strategies, on an ongoing basis.

b. Consult, provide technical assistance and participate in prevention planning activities for the other department as appropriate or necessary. This may include programs where each Department has its own implementation mechanisms, but can benefit from joint participation;

c. Work together to review clinical preventive priorities and standards and implement prevention and treatment approaches consistent with guidance from the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, the California Department of Health Services, or other prevention authorities, as appropriate; and

d. Collaborate on grant applications and research programs designed to test or improve clinical preventive service approaches.

Appendix A.6 **Tuberculosis Services**

DHS and DPH agree to perform necessary and/or legally mandated Tuberculosis (TB) services in accordance with the policies and procedures incorporated in the Los Angeles County Tuberculosis Control Program (LAC TBC) Manual, including, but not limited to, the following:

a. Targeted Testing and Treatment of Latent Tuberculosis Infection (LTBI): Screening for tuberculosis (TB) performed by DHS and DPH shall be in accordance with guidelines of the Centers for Disease Control and Prevention (CDC) and standards contained in the LAC TBC Manual.

b. Diagnosis and Management of TB Disease: Diagnostic work-up of a person suspected of having active TB disease shall be in accordance with guidelines of the CDC and standards contained in the LAC TBC Manual.

   A person diagnosed as a TB suspect or case shall be offered therapy and monitored. DHS shall refer a TB suspect or case to the DPH Public Health Center nearest the patient's residence, unless otherwise requested by the patient, for continued management, treatment (including directly observed therapy, if needed) and follow-up. As indicated during the course of case management, DPH will refer a TB suspect or case for additional diagnostic and referral services (including but not limited to additional radiologic studies, invasive diagnostic procedures, and surgical procedures).

   A person identified as a suspect or case of TB must be reported to TBC within 24 hours in accordance with applicable laws, regulations and policy directives.

c. Discharges of TB Suspects and Cases from Health Facilities: The discharge or release of a TB suspect or case from a DHS facility shall be based on TBC approval of a written treatment plan.

d. Health Officer's Orders for TB: DHS agrees to admit a TB suspect or case who is under a Health Officer's order (such as civil order of detention) to an appropriate DHS facility in accordance with HSC section 121366 and County Code, and shall retain the patient for the duration specified by the local Public Health Officer.

e. Reimbursement for TB inpatient days in DHS hospitals: Effective July 1, 2006, DPH will reimburse DHS for inpatient days of TB patients in DHS hospitals, who meet both of the following status categories:

   Category 1 - Patients whose medical condition no longer requires an acute level of care, but who cannot be discharged because they are: a)

still contagious and are either under detention order or homeless, or b) non-contagious, but their discharge is delayed by efforts in identifying placement due to homelessness; and

Category 2 – Patients who are either ineligible for Medi-Cal, Medicare or other third party coverage, or eligible for such coverage but payment for days of care has been denied by the payer because of non-acute medical status. Prior to this agreement, costs for these patients have been assumed within the DHS hospital budgets. Reimbursement by DPH will be based on the weighted average of variable cost per day for TB patients in DHS hospitals.

Subject to approval by the Board of the separate DPH, the Chief Administrative Office will work with DHS and DPH, during the 2006-07 Budget process, on adjustments to the DHS and DPH budgets to reflect this transfer of financial responsibility. To accomplish this, DHS and DPH staff will develop information regarding numbers of inpatient days for TB patients, meeting the requirements identified above, and variable cost per day for TB patients at the DHS hospitals. This will serve as the basis for the budgetary adjustments to transfer net County cost from DHS hospitals to DPH and to increase Other County Department (OCD) revenue for the DHS hospitals by the same amount, for no net change in operating subsidy.

Should the actual numbers of TB patients meeting the criteria exceed the numbers projected in the 2006-07 and subsequent budgets, DPH will be responsible for providing reimbursement, as identified above, to the DHS hospitals, using their existing resources.

DPH may determine that it would be more cost-effective or beneficial to seek alternative resources for these patients, including contracts with skilled nursing facilities or housing providers, rather than utilizing the inpatient days at DHS facilities, and may use the appropriation and net County cost provided to them in this adjustment for that purpose. If DPH decides to use alternative resources, DPH shall advise DHS.

Further, DPH agrees to submit an application for reimbursement for civil detention to the California Department of Health Services, Tuberculosis Control Branch (CDHS -TBCB), in accordance with the CDHS -TBCB Policies and Procedure Manual, for each TB suspect or case under a Public Health Officer's civil order of detention and detained in a DHS facility.

The DHS facility is responsible for invoicing the CDHS -TBCB, in accordance with the CDHS -TBCB Policies and Procedure Manual, for each TB suspect or case under a Health Officer's civil order of detention

and detained in a DHS facility, and approved for reimbursement by CDHS -TBCB.

The DPH TB Control Program will notify the DHS facility when a TB suspect or case is to be released from a civil order of detention. The TB Control Program will notify the CDHS -TBCB Civil Detention Coordinator within 5 days of the release date.

f. Airborne Infection Isolation Ward: DHS agrees to continue to develop and maintain an airborne infection isolation ward meeting the requirements of Cal-OSHA and guidelines of the CDC to isolate and treat TB suspects and cases as determined by the local Public Health Officer to protect public's health (currently part of the capital project at Olive View Medical Center for the emergency department).

Appendix A.7 **Sexually Transmitted Disease Services**

DPH agrees to continue providing categorical STD clinics at locations listed on Exhibit III.

DHS agrees to continue providing diagnostic services and medical care to patients referred from DPH STD Clinics, including, but not limited to: Dermatology, OB/GYN, Urology, GI/Liver, Family Planning, Neurology, Infectious Disease, HIV care, and primary care, via an established referral process.

DHS will continue to provide STD screening and treatment in their facilities consistent with national STD treatment guidelines (Sexually Transmitted Disease Guidelines, CDC, 2002).

DHS agrees to continue providing cytologic evaluation of pap smears sent from three (3) DPH STD Clinics. DHS further agrees to consider providing these cytologic services and associated HPV testing technology to DPH's remaining STD Clinics. DPH will be charged for this service at DHS public rates based on cost. DHS will compare costs to Medi-Cal rates when developing its fee schedule.

DPH agrees to provide staff services for STD surveillance, public health investigation and partner notification services for DHS referrals. DHS agrees to provide adequate space at appropriate DHS facilities to house DPH's Hospital Liaison Nurses for these services, as well as access to relevant patient charts.

Appendix A.8 **HIV/AIDS Services**

DHS maintains an existing network of HIV primary and specialty care services, as prescribed in separate agreements between DPH Office of AIDS Programs and Policy (OAPP). DHS agrees to maintain these services in accordance with these agreements, as long as these agreements are in effect. These services include, but are not limited to, ambulatory outpatient medical care, HIV/AIDS medical specialty care, psychiatric and mental health care, state-of-the-art treatment for HIV/AIDS and related conditions and comorbidities, therapeutic and diagnostic monitoring services, AIDS Drug Assistance Program (ADAP) and Medi-Cal/Medicare enrollment, oral health care, HIV/AIDS Counseling and Testing services, and the associated data collection and reporting requirements, as appropriate.

DHS further agrees to inform DPH if it makes any significant changes to programs at DHS facilities that may not be funded by DPH/OAPP, but which affect DPH HIV-related program areas indicated above.

DHS agrees to continue to provide its HIV care consistent with national practice standards and adhere to existing treatment guidelines as described in the following:

a. *STD Treatment Guidelines for People Living with HIV,* CDC, 2002;

b. Principles of Therapy and Revised Recommendations for the Prevention *and Treatment of TB Among Persons Infected with HIV,* MMWR, 1998; and

c. *USPHS/AAHIVM Guidelines for the Treatment and Management of HIV-1 Infection.*

DPH OAPP agrees to provide funding as available and consistent with current allocation methodologies, activities and mandates of the Los Angeles County Commission on HIV. DPH OAPP agrees to provide consultation and monitoring activities to ensure DHS facilities are familiar and compliant with all of the County, State and federal requirements for delivering and reporting HIV/AIDS-related services.

Appendix A.9 **Immunization Services**

All DHS facilities that provide pediatric immunizations agree to continue participating in the Los Angeles-Orange Immunization Network (LINK) in accordance with the standard MOU already in existence for this project, and DHS facilities not yet participating will be added according to an agreed upon timetable.

Appendix A.10 **Substance Abuse Services**

DPH will assume administration of the Antelope Valley Rehabilitation Centers (AVRCs) on July 1, 2006, upon the creation of a separate budget unit. A separate MOU and implementation plan will govern the transition and continued operation of the AVRCs.

DPH's Alcohol and Drug Program Administration (ADPA) will continue to work with DMH and DHS to increase and improve the capacity for substance abuse screening and referral at DHS facilities, including the psychiatric emergency services at the four County hospitals, dependent on available resources. The pilot projects are underway at King/Drew (Augustus Hawkins), LAC+USC, Olive View and Harbor-UCLA. Additional information regarding the roles and responsibilities will be reflected in the Memorandum of Understanding between DHS, DPH and DMH for mental health services.

Appendix A.11 **Homeless Services**

Homeless Prevention Coordinators (HPCs) will be available in both DHS and DPH. The HPCs in DHS and DPH will work collaboratively to oversee any health related issues related to homelessness, and will coordinate their efforts on any tasks related to homelessness that involve both personal and public health care issues.

The HPC in DHS will be responsible for oversight of personal healthcare issues that ensure that the LA County healthcare facilities are accessible and responsive to the needs of persons who are homeless. This includes, but is not limited to, discharge planning; increasing supportive housing and other resources; and providing training and support to DHS staff in relation to homelessness issues.

The HPC in DPH will be responsible for oversight of public health issues in relation to homeless services in LA County. This includes, but is not limited to providing public health and health literacy information/training for homeless service providers and ensuring ongoing communication for such service providers.

Appendix A.12 **Family Planning Services**

Title X funding for family planning services will be transferred from DPH's Maternal, Child, and Adolescent Health unit to DHS and DPH will no longer serve as the interface between the California Family Health Council, Inc. and DHS' personal health facilities. DHS will assume direct responsibility for administering these funds and any resulting contracts with partner facilities.

Appendix A.13 **California Children's Services (CCS)**

DPH CCS assigns nurse case managers to Harbor-UCLA, LAC+USC and Martin Luther King, Jr./Drew Medical Centers, to assess pediatric (through age 21) inpatient referrals and medical reports to determine CCS eligibility; assist with the application process; identify needed services (inpatient, durable medical equipment, skill nursing, medical supplies, outpatient follow-up, etc.) and request appropriate authorizations; educate providers, families, and clients regarding CCS eligibility and benefits; and serve as a liaison between the facility, family, and primary CCS case manager, among other duties. The assignment of staff is based on pediatric Medi-Cal inpatient census and a change in census may result in a change in staff assignment.

DPH, through the CCS program, agrees to:

a. Assign one nurse case manager to identified DHS hospitals and provide a computer and clerical staff support for nurse activities.

b. Participate in quarterly management meetings with each hospital to ensure continuous quality improvement and address operational, administrative, and policy issues.

c. Develop, implement, and evaluate programs to educate hospital staff regarding CCS programs and services.

d. Serve as a consultant to the hospitals regarding claims processing and payment issues.

DHS facilities agree to:

a. Appoint a liaison to coordinate activities with CCS and CCS nurse case manager, and ensure appropriate staff participation in CCS educational programs.

b. Participate in quarterly management meetings with CCS to ensure continuous quality improvement and address operational, administrative, and policy issues.

c. Provide CCS nurse case manager with access to medical records, medical reports, medical information, medical conferences, discharge planning rounds, etc., so that the nurse case manager can perform the duties described above.

d. Provide CCS staff with adequate office space to include furniture, computer connectivity, fax, and telephone.

Appendix A.14 **Office of Women's Health**

Improving the health status of women throughout the lifecycle is critical within both DHS and DPH. The Office of Women's Health (OWH) serves as a focal point to make both DHS and DPH programs and policies more responsive to women receiving care within publicly funded programs and services. OWH promotes comprehensive and effective approaches to improving women's health and focuses on the coordination of existing programs and resources.

DHS agrees to work with the DPH Office of Women's Health to:

a. Work with model women's health programs in hospitals, comprehensive health centers, health centers and/or programs and, through OWH technical assistance, share information and knowledge to enhance quality, systems, and resources of other like programs.

b. Continue providing the current scope and volume of diagnostic services and medical care to patients with an abnormal result referred from the OWH mobile clinic, the Hotline, and the OWH website.

c. DHS will continue to provide OWH with the use of the existing mobile van for their mobile clinic outreach program, and expenses will continue to be paid by the OWH.

DPH Office of Women's Health agrees to:

a. Continue operation of its 1-800-793-8090 appointment and referral hotline, making appointments for no or low cost screenings into the OWH network of county and community providers.

b. Provide free preventive health screenings to include cholesterol, diabetes, blood Pressure, Body Mass Index, and Pap tests as well as gynecological and breast exams via its mobile clinic outreach, referring patients for follow-up care into the county and community network.

Appendix A.15 **Health Services Information Unit**

DPH operates the Health Services Information Unit, which is a telephone information and referral line for the public. Through the end of FY 2005-06, DPH will continue to answer calls related to DHS services and make appropriate referrals. Examples of high-volume calls of this nature include questions about the Ability-to-Pay program and referrals to DHS, PPP, or GR health care facilities.

For FY 2006-07 and beyond, DPH will assess the feasibility of transferring this function to Infoline's 211 service. DPH will continue to answer these calls until the transfer is completed, and DPH and DHS staff will develop a reimbursement mechanism for costs associated with this service.

Appendix B **ADMINISTRATIVE SERVICES**

While DPH has been provided with administrative support positions as a result of its establishment as a separate Department from DHS, there are areas where a sharing of resources is necessary and will continue, either on a short-term, interim basis, or for a longer term, as described and agreed to in the succeeding appendices.

Appendix B.1 **Human Resource Management**

DHS will continue to maintain, and allow DPH to utilize, the Item Management System. Any new upgrades will be provided to DPH.

DHS will include DPH in its ongoing development of the Time Management System and structure any competitive processes so that DPH can be served by the same vendor(s) through integrated or separate agreements, whichever is determined to be most efficient.

DHS and DPH will agree upon an appropriate reimbursement mechanism for costs associated with these services.

Appendix B.2 **Employee Health Services**

DHS facilities will continue to provide employee health services to DPH, until a contract provider for DPH can be obtained. Projected date for implementation of the contract is July 1, 2007. DHS and DPH will agree upon an appropriate reimbursement mechanism for costs associated with these services.

Appendix B. 3 **Risk Management**

DHS maintains a vendor supported electronic incident reporting system (Patient Safety Net-PSN) that incorporates Public Health Centers as units within Health Services Administration's functional structure.

DPH agrees to continue to maintain the administrative functions related to the PSN program (e.g., determine access for assigned staff, maintain data base) for the units listed within Health Services Administration for the duration of the contract period, which ends December 31, 2008. This contract does not include a budget for PSN onsite training for DPH, or the purchase of any training materials, i.e., PSN Guide to Event Types.

PSN will provide DHS a monthly data download in an Access database.

a. DHS and DPH will collaborate to determine which specialized reports DPH will require.

b. DPH will reimburse DHS for the staff time related to the preparation and delivery of these reports.

DHS will continue to provide administrative oversight for DPH Risk Management claims at the current scope and volume of service.

Appendix B.4 **Facilities and Space Management**

DHS and DPH will continue to operate the facilities they currently operate and be co-located in the buildings in which they are currently co-located. In each co-located facility, including administrative headquarters, the department with the majority of the space at the time of separation will be the "landlord," operating the building. The other department will pay its share of operating costs for the facility. DHS and DPH will agree upon an appropriate reimbursement mechanism for these costs.

As they are the majority occupants, DHS will serve as the landlord for 313 N. Figueroa (and 241 N. Figueroa, since they share many services) and 5555 Ferguson. Decisions about increases or decreases in space and or support services will be negotiated between the departments, subject to approval by the Chief Administrative Office.

Appendix B.5 **Information Systems: Applications, Infrastructure and Services**

Data collection and analysis and information dissemination are essential to both DHS and DPH. The existing information technology infrastructure that supports both departments is complex and closely links DHS and DPH. Some existing information technology (IT) services have been designed to provide more efficient or cost-effective delivery of information systems support and operations. Separation of responsibilities will be designed to maximize organizational autonomy, while preserving interdepartmental cooperation and maintaining existing service levels. No significant changes in responsibilities are expected.

No charges for services between DHS and DPH are anticipated during the initial transition period, approximately through June 30, 2006. Cost for services from the Internal Services Department will continue to be charged to DHS and DPH budget units as appropriate. Further discussion will be conducted by DHS, DPH and Chief Administrative Office staff to appropriately identify costs for applications, shared infrastructure, and services that may be billed to the appropriate department. Budgetary adjustments, as needed, will be made during the budget process.

The following IT services are now provided to DHS users by Public Health Information Systems (PHIS). PHIS will continue to provide the same services to DHS after the separation.

a. Applications

    i. Assignment Tracking systems (as requested)

b. Infrastructure

    i. None

c. Services

    i. Local area network (LAN) support at locations where DPH users are in the majority.

        1. Glendale Health Center - 501 N. Glendale Ave., Glendale, CA

    ii. LAN user support at locations where DPH users are not in the majority.

        1. Ferguson Complex - 5555 Ferguson Drive, Commerce, CA

iii. Personal computer (PC) support for DHS users at locations where DPH users are in the majority.

1. Glendale Health Center - 501 N. Glendale Avenue, Glendale, CA

iv. PC support for DHS users at locations where DPH users are not in the majority.

1. Ferguson Complex - 5555 Ferguson Drive, Commerce, CA

The following IT applications and services are now provided to Public Health users by DHS Information Resource Management (IRM) and other DHS administration or facility-based IT organizations. DHS IS will continue to provide the same services to DPH after the separation. In order to maintain compliance with Health Insurance Portability and Accountability Act regulations on privacy and security of protected health information, DHS requires a common base security profile at the desktop level. Users requiring assistance with their computers will first call their assigned departmental (DHS or DPH) service desk. The service desk will then relay service tickets to the appropriate (DHS or DPH) PC support staff to deliver on-site services where necessary. Assignments for PC support are listed below.

a. Applications (includes hardware and operating systems administration, application administration, end-user support)

i. Item Management (DHS human resource management application)

ii. Labor Cost Distribution (LCD DHS financial reporting application)

iii. QuadraMed Affinity (DHS clinical information system) at designated Public Health clinics

b. Infrastructure

i. Novell GroupWise Internet Access (GWIA)
ii. Novell GroupWise WebAccess
iii. Novell GroupWise intra-post office routing
iv. Novell eDirectory and LDAP
v. Blackberry Enterprise Server
vi. Email virus and spam filtering
vii. Internet proxy server filtering and reporting
viii. Internet web servers
ix. Intranet web servers
x. Firewalls
xi. Internet access from shared facilities

x. Firewalls
xi. Internet access from shared facilities
xii. Videoconferencing capability from Figueroa Complex

c. Services

i. Novell GroupWise GWIA administration

ii. Novell GroupWise WebAccess and post office administration and end-user support for shared post offices or for DPH post offices hosted in DHS data centers/computer rooms

iii. Directory (Novell eDirectory) administration and sync with DHR CWTAPPS data

iv. Blackberry Enterprise Server administration and end-user support

v. Proxy ad hoc reporting

vi. Internet and Intranet DPH web site development, maintenance, and operations support

vii. Data Center provisioning for DPH servers located at:

1. Figueroa Complex/DHS Data Center – 313 N. Figueroa St, Los Angeles, CA

viii. LAN user support and infrastructure management at locations where DHS users are in the majority.

1. Ferguson Complex – 5555 Ferguson Dr, Commerce, CA

2. Figueroa Complex – 241 and 313 N. Figueroa St, Los Angeles, CA

3. All DHS hospitals and clinics where there are co-located PH users

ix. LAN infrastructure management at locations where DPH users are in the majority.

1. Adams & Grand – 2615 S. Grand Ave, Los Angeles, CA

2. Alhambra – 1000 S. Fremont Ave, Alhambra, CA

3. Baldwin Park – 5050 Commerce Dr, Baldwin Park, CA

4. Commonwealth – 600 S. Commonwealth, Los Angeles, CA

5. Downey – 7601 E. Imperial Highway, Downey, CA

6. Norwalk – 12440 E. Imperial Highway, Norwalk, CA

7. Santa Fe Springs – 10430 Slusher, Santa Fe Springs, CA

8. Telstar – 9320 Telstar Ave, El Monte, CA

9. Torrance – 711 Del Amo Blvd, Torrance, CA

10. Wilshire Metroplex – 3530 Wilshire Blvd, Los Angeles, CA

11. Vermont – 695 S. Vermont, Los Angeles, CA

x. Wide area network (WAN) coordination and support at all locations (actual data transport services for the Enterprise Network provided through ISD)

xi. PC support at locations where DPH users are not in the majority.

1. Figueroa Complex – 241 and 313 N. Figueroa St, Los Angeles, CA

2. Alhambra (OMC only) – 1000 S. Fremont Ave, Alhambra, CA

3. All DHS hospitals and clinics where there are co-located DPH users

The following IT services are provided to DHS by Internal Services Department. ISD will continue to provide the same services to DHS and DPH after the separation.

a. Materials Management System

b. CWTAPPS (County-Wide Time, Attendance, Personnel, & Payroll System)

c. CWPAY (County-Wide Payroll System)

d. HMMS (Health Materials Management System)

e. CAMIS (County-Wide Asset Management Information System)

f. eCAPS (Electronic Countywide Accounting Purchasing System)

g. CAPS (Countywide Accounting Purchasing System)

h. Internet access from DPH-only facilities

i. Internet hosting services

j. Enterprise Network (coordination and management services provided by DHS)

The following IT service is provided to DHS by the Department of Public Works (DPW). DPW will continue to provide the same service to DHS and DPH after the separation.

a. eDAPTs (electronic Development and Permit Tracking System)

The following IT services are provided to DHS by vendors. These vendors will continue to provide the same services to DHS and DPH after the separation using the existing contracts with DHS. New contracts with DPH will be required when the existing contracts expire.

a. FileTrail (Human Resources)

b. Medical Transcription Services (Children's Medical Services - new contract pending, July 2006)

Appendix B.5.1 **Information Systems: Data Sharing**

DHS and DPH will continue to share planning data, as requested by each department, as follows: DPH will continue to provide population-level health data, such as data from the Los Angeles County Health Survey and vital statistics data, among other data, and DHS will provide health facility data, such as DHS facility data and Office of Statewide Health Planning and Development (OSHPD) data.

As recognized by the Board of Supervisors (Board), DHS is included in the Healthcare Component of the County, with respect to their receipt of Protected Health Information (PHI), pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This status is shared by Public Health as part of DHS. If established by the Board as a separate department, DPH will need to be recognized by the Board as a Covered Component of the Healthcare Component, in order to continue to receive PHI from other Covered Components. Covered Components currently include DHS, the Department of Mental Health, the Dorothy Kirby Center of the Probation Department, the Department orf Human Resources' Employee Benefits Division, and the Pharmacy Division of the Medical Services Bureau of the Sheriff Department. In that event, DPH shall, by March 31, 2006, develop its required HIPAA compliance plan and execute the required Memoranda of Understanding with the Chief Administrative Office, Auditor-Controller, Treasurer- Tax Collector, Internal Services Department, and County Counsel.

Further, by March 31, 2006, DHS and DPH, in consultation with County Counsel, shall identify instances where patient or client specific information is shared between the departments and develop procedures, as necessary, to ensure that the information will continue to be shared. Further DHS, DPH and County Counsel will review barriers to the sharing of information between DHS and DPH, which may exist regardless of whether DHS and DPH are separate or the same department, so that action steps can be developed to remove those barriers.

By June 30, 2006, DHS and DPH, in coordination with the Chief Information Office and the CAO, shall review the data systems maintained by each department, in order to identify opportunities for pursuing uniformity and improved communication between systems.

Appendix B.6 **Library Services**

The Public Health Library at 313 N. Figueroa will continue to provide reference service and resources for DHS administrative staff; continue to participate in consortia purchasing agreements with DHS libraries, as appropriate; and continue in mutually agreeable cases as "enterprise librarian" for consortia purchase and to provide liaison services between the DHS librarians and DHS IT.

DHS will continue to provide $10,000 to support DHS administrative staff's research needs (this amount can be adjusted annually based on DHS' needs); continue to provide DPH access to all DHS-wide non-library funded, electronic literature and database resources at no charge to DPH; include DPH in consortia purchasing agreements with DHS libraries, and reimburse DPH for expenses to provide access to DHS facilities for electronic journals, as requested by DHS.

Appendix B.7 **Training Programs**

DHS and DPH provide staff training programs which may be attended by staff of the other department. Both DHS and DPH agree that this practice will continue, with no charges between departments for participation by these staff, through June 30, 2006. Upon the effective date of this MOU, DHS and DPH will meet to identify those training programs which might be of interest and value to staff in the other department, on an on-going basis, and determine whether it is more cost-effective and/or efficient that separate training programs should be developed or that DHS and DPH staff should continue to participate in the training programs sponsored by the other department. If it is determined that continued participation by staff of the other department is more cost-effective and/or efficient, DHS and DPH will agree upon an appropriate reimbursement mechanism for the training costs associated with participants of the other department, which would become effective on July 1, 2006.

Appendix B.8 **Agreements and Board Delegated Authority**

Effective with the creation of the DPH, DHS and DPH will each administer the contracts and subcontracts which exist in the DHS before separation and which are related to each DHS and DPH function. Such agreements shall be construed to refer to the Director or designees of DHS or DPH, depending on the services provided. If any disagreement exists on which department shall administer an agreement, the departments will seek the advisement of the Chief Administrative Office and County Counsel in determining the appropriate department to administer the agreement.

For agreements such as custodial or environmental, which contain services to both DHS and DPH facilities, the department serving as the building landlord will continue to administer the agreement for the benefit of both departments, in consultation with the other. DHS and DPH will mutually agree on a schedule for resolicitation of such agreements and determine whether the resolicitation shall be done jointly or separately.

For delegated Board authority to accept grant awards, accept amendments or to enter into agreements approved by the Board prior to the separation, the delegated authority shall be interpreted to refer to the DPH Director or designee, when the agreements are administered by DPH as described above.

Appendix B.9 **Countywide Coalitions, Committees, and Commissions**

Prior to the establishment of separate Departments of Health Services and Public Health, a single representative served on numerous coalitions, committees, and commissions on behalf of both DHS and DPH. Effective upon the creation of the separate DPH, representation to these groups will be determined on a case-by-case basis, as agreed to by both departments, with the following guidelines, and will be included as an addendum to Appendix B.7:

a. Countywide groups comprised of department heads from each department, such as New Directions Task Force and the Interagency Operations Group, will include participation from both DHS and DPH.

b. Groups governed by ordinances, such as the First 5 LA (Proposition 10) commission, Children's Planning Council, various commissions, will be decided on a case by case basis, with the department most engaged in the issue generally serving as the representative, or both departments will be represented, and necessary ordinance changes will be enacted.

c. Coalitions and committees without formal membership criteria will be decided on a case by case basis, according to the subject matter and level of interest by each department.

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c. Coalitions and committees without formal membership criteria will be decided on a case by case basis, according to the subject matter and level of interest by each department.

Attachment 6

COUNTY OF LOS ANGELES

PUBLIC HEALTH COMMISSION

PUBLIC HEALTH COMMISSIONERS

Larry Roberts, M.P.A., Chairperson
Second District

Michelle Anne Bholat, M.D., M.P.H., Vice-Chairperson
Fourth District

Lester Breslow, M.D., M.P.H.
Third District

Keri Gardner, M.D., M.P.H.
Fifth District

Sarita A. Mohanty, M.D., M.P.H.
First District

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
241 N. Figueroa St., Room 109
Los Angeles, CA 90012
(213) 240-8377
(213) 481-2306 FAX

FEB - 3 2006

February 2, 2006

TO: Sheila Shima
CAO Representative

FROM: Larry Roberts, Chair
Public Health Commission

SUBJECT: **PUBLIC HEALTH COMMISSIONERS' COMMENTS ON MOU**

Attached you will find comments from the Public Health Commissioners regarding our discussion of the MOU. The comments are listed on the attached by Supervisorial district.

1st District – Dr. Sarita A. Mohanty
2nd District – Larry Roberts
3rd District – Dr. Lester Breslow
4th District – Dr. Michelle Anne Bholat
5th District – Dr. Keri Gardner

If you have any questions, please contact me or the Commission office at (213) 240-8377.

LR:ah

Attachments

c: Dr. Jonathan Fielding
Dr. John Schunhoff

Attachment I

Comments regarding the memorandum of understanding
Presentation 1-26-2006
Public Health Commission
S.A. Mohanty

Overall, the draft MOU was organized very nicely and was easy to follow.

- It will be important to make sure that communication is maintained between the DHS and DPH. I worry that there may be more administrative burdens faced by each Department, and there may be neglect in discussion during the transition.
- I particularly liked the option of being able to add supplemental materials in the appendices
- I am concerned about the fact that DHS and DPH may have their own implementation mechanisms re: prevention (Appendix A.5) but can benefit from joint participation. Shouldn't prevention planning be integrated? Which ones may be separate and which may be integrated? This needs further specification.
- There must be definite collaboration when it comes to research programs designed to test or improve clinical preventive services approaches. Research cannot be fully effective without such collaboration. Goals should be set in place to look at potential joint research opportunities.
- Key to this will be a sound IT infrastructure, including electronic medical record so as to provide the best communication between the two departments. Otherwise, there may be increased room for error (patients 'falling through the cracks' or getting 'lost in the system') during the separation of DPH and DHS.
- It is still unclear how DPH's ADPA will work with DMH and DHS. What are the roles of each Dept within this program? This should be specified.
- Homeless Prevention Coordinators: it is the understanding that this will be the work of a DPH nurse and a DHS social worker. Evaluation of these coordinators will be essential to make certain that all the needs of the homeless are met. Is the staffing appropriate? Is there ample and appropriate communication between the DHS and DPH coordinators? Who is evaluating this coordinator process currently?
- Still awaiting revisions of the 'Office of Women's Health' – this will be set up in DHS? Will DHS have their own preventive services or will they share the services with DPH? This is unclear.
- There should be discussion about DHS and DPH roles re: the elderly/aging population and the disabled. Work with these subgroups should be discussed in the near future and placed as appendices.
- The sharing of data between DPH and DMH must be clearly delineated. Without proper sharing of data, it will be very difficult to move forward with quality improvement strategies for patients. HIPAA requirements, etc. must be sorted out before this separation.
- Training programs: need to identify how potential separation of training programs may impact training of residents and medical students at teaching facilities. It is essential that this separation not impact negatively on the training programs.
- How much do the physicians, staff, administration know about the separation of

DPH and DHS? Have they been made readily aware of the changes to ensue? Need ongoing communication (memos, media) so that staff is not taken by surprise about the potential changes.

- EMS staff should be made aware of changes and to whom to report. Extensive training and awareness needed for EMS before changes are fully implemented.

Attachment II

January 31, 2006

TO: Sheila Shima
CAO Representative

FROM: Larry Roberts, Chairman
Public Health Commission
Second Supervisorial District

SUBJECT: **MOU COMMENTS/RECOMMENDATIONS**

I The separation of Public Health and Personal Health should not result in a net increase in county cost.

II It is imperative that patients in need of services not be shuttled from a personal health facility to a public health facility resulting in patients falling through the cracks because of confusion. How will patients and/or the public know the difference between a public health center and a personal health center?

III It is also imperative that service integration continue to be vigorously pursued.

IV This MOU does not appear to have an oversight/mediation component between the two separate departments to resolve the inevitable disputes that could impede patient services. This kind of oversight is absolutely essential.

I make these comments and recommendations as one who was Deputy Director, Health Center Operations, Department of Health Services, from April 1986 to January 1993.

I was responsible for the six (6) Comprehensive Health Centers, thirty-nine (39) public health centers and the Juvenile Court Health Services division that provided medical services to the Los Angeles County's Juvenile Centers and Probation Camps.

Attachment III

Per Dr. Lester Breslow:

My comments on the MOU at the January 26, 2006 meeting were:

1. It is a huge and excellent piece of work
2. The Health Officer and prospective Director of the new Department of Public Health have no significant problems with it.
3. The possible establishment of the Health Authority to replace the current Department of Health Service's responsibility for operating the County's hospitals and clinics, as proposed by many agencies in the county, should entail consideration of some amendments to the MOU.

Attachment: IV

February 1, 2006

To: Mr. Larry Roberts, MPA
Chair, Public Health Commission

From: Michelle Anne Bholat, MD, MPH
Vice Chair, Public Health Commission

Subject: Comments on DRAFT MOU between the Los Angeles County Department of Health Services and the Los Angeles County Department of Public Health

Comments Appendix A.1 – A.15

1) In order to meet the intent of DHS and DPH to insure that the services offered by both departments are coordinated and that the principles of prevention and health promotion are integrated into DHS' clinical services, I therefore recommend that each DPH program listed in the MOU and the corresponding hospital group attend the Public Health Commission meeting to advise the Committee of concerns, issues and successes during the separation transition.

2) Oral Health – Given that DHS and JCAHO inspections are now unannounced and that the goal of any health facility is to be ready for the 'next patient walking in the door', I would ask that the DPH look carefully at the total hours invested in inspections. In addition, the volume of patients is also an important consideration and future goals of oral health given the lack of dental care to the uninsured.

3) Radiology Services – Recommend reviewing the cost of registry staff vs. hiring staff that could be shared between DHS and DPH.

4) Pharmacy Services - Consider a DHS and DPH Pharmacy and Therapeutics committee to review the medication formulary and the volume of doses to be stored at each public health site. Although 340 B prices are often lower, they are not always and a mechanism for annual review of costs between both sites on the same medications should be reviewed/

5) Laboratory Services – DHS and DPH need to develop an education plan to advise DHS, DPH and non-DHS/DPH physicians, nurses and purchasing group of proper specimen collection technique and equipment.

6) Preventive Services – Consider screening DHS and DPH guidelines for the evaluation and treatment of diseased noted in the MOU draft. In addition, consideration for treatment of alcohol, met amphetamine, prescription drug abuse etc. should be an area of collaboration and the development of integrated evaluation and treatment plans between DHS, DPH and DMH.

7) Tuberculosis Services - Standardize the care, treatment and services of TB throughout Los Angeles County DHS and DPH facilities. Education DHS physicians on treating and report all stages of TB.

8) Sexually Transmitted Disease Services – Standardize the care, treatment and services of STI's throughout Los Angeles County DHS and DPH facilities. Education DHS physicians on treating and report all stages of STI.

9) HIV/AIDS Services – Determine the number of cases of HIV/AIDS within the DHS system and determine if standardized care is being provided in all facilities.

10) Immunization Services – Monitor the use of LINK at DHS, DPH and non-DHS/DPH facilities. If the system works for the staff and patients why? If it doesn't work for the staff and patients then why not?

11) Substance Abuse Services –Task force to review medication treatment for addition as well as cognitive behavioral therapy approaches.

12) Homeless Services – DPH ACD to develop guidelines for DHS, DPH and non-DHS/DPH physicians and nurses in the treatment of MRSA and Hepatitis A and other communicable diseases.

13) Family Planning Services – Would like to review revisions to this Title X Program. If DHS assumes direct responsibility then how do the Public Health Nurses interface with this program? This is an area that deserves further review.

14) California Children's Services (CCS) – How many clients, how many nurse case managers? Does the program work? Why or why not?

15) Office of Women's Health. How does this differ from Family Planning Services? Is this redundant?

15) Health Services Information Unit. Whether DHS or DPH manages this unit, information to all health care providers and the public needs a marketing campaign in order that people of Los Angeles County can connect to our services.

1

Attachment V

Memorandum

To: Larry Roberts, MPP
Chairman, Los Angeles County Public Health Commission

From: Keri Gardner, MD, MPH
Los Angeles County Public Health Commissioner

Date: 1/31/2006

Re: MOU for separation of Departments of Public and Personal Health

On 26 January 2006 at the meeting of the Public Health Commission we discussed the MOU regarding the separation of the Departments of Public and Personal Health. After review of the document I have the following comments:

First, I appreciate the extensive work that has been done by the Chief Administrative Officer, Dr. Fielding, Mr. Schunhoff, and all the staff that have clearly worked extensively on the document. The MOU provides an excellent template for the proposed separation.

My main concern regards the areas in which the MOU delineates cooperation between the DPH and DHS in the care of patients with conditions that span both services. While cooperation between departments is essential, I am concerned that the absence of clear leadership for a particular service might disjoin care. For example, patients with TB will be referred to DPH for continued management and follow up, but there is a foreseeable potential lapse of communication between departments. Also, in the care of the homeless, there is a possible gap between services and care provided by the two departments. For this reason I would recommend that each service have a single department identified that has the primary responsibility that service. With one single department having primacy in coordination of care, there would be clear authority for the resolution of problems in service provision as they arose.

My third comment is to reinforce what is already recognized as an important issue, which is that top priority should be given to using the same information technology systems between the various service units of the two departments.

Lastly, on a very minor note: We Emergency Physicians would like to request that our work environment be referred to as "emergency department" rather than "emergency room" as is noted in the last paragraph of Appendix A.6. Thank you for considering this in official county documents, even though common vernacular and the television drama run contrary.

Respectfully yours,

Keri Gardner

Los Angeles County
HOSPITALS AND HEALTH CARE DELIVERY COMMISSION

313 N. Figueroa Street, Room 904, Los Angeles, CA 90012
(213) 240-7768 Fax: (213) 482-9421

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ANTELOPE VALLEY
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Acton

Warm Springs

February 8, 2006

Janssen
Harper
Lizzari
Shima

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CHIEF ADMINISTRATIVE OFFICE

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, Ca. 90012

Dear Supervisors:

On February 2, 2006, the Hospital And Healthcare Delivery Commission met with Doctors Chernof and Fielding, staff from the Department of Health Services (DHS), County Counsel and representatives of the Chief Administrative Office (CAO), to discuss the proposed separation of the Public Health Division from DHS. Prior to this meeting, each Commissioner reviewed the motions by Supervisor Knabe and draft Memorandum of Understanding (MOU).

After listening to the presentation of Doctors Chernof and Fielding and reviewing the motions and MOU, it is the unanimous opinion of the Commission that Public Health should remain part of DHS. The agencies share a purpose and mission of improving the health of the citizens of Los Angeles County. Although Public Health is charged with addressing health issues affecting the broader public, that mission clearly fits under the umbrella of DHS. The MOU itself demonstrates the vast interrelation of these entities and suggests that they cannot be separated.

Furthermore, at this time of fiscal uncertainty for the County separating these entities will likely have an adverse impact on the County's finances, including DHS, in this and future budget cycles. Although the CAO projects that a new Department of Public Health could be created with " no new net County Cost," there is no evidence that expanding the County government can or will occur without corresponding growth in spending.

In summary, the Commission believes that there is no compelling reason to separate the two entities at this time.

The Hospital And Healthcare Delivery Commission stands ready to provide further comment on this or other matters at the pleasure of the Board.

Very truly yours,

Stanley Toy, M.D.

Stanley Toy, Jr. M.D., Chair,
Hospital And Healthcare Delivery Commission

ST/ljp

c: Bruce Chernof, M.D., Acting Director,
Department of Health Services

Jonathan Fielding, M.D., Director,
Public Health

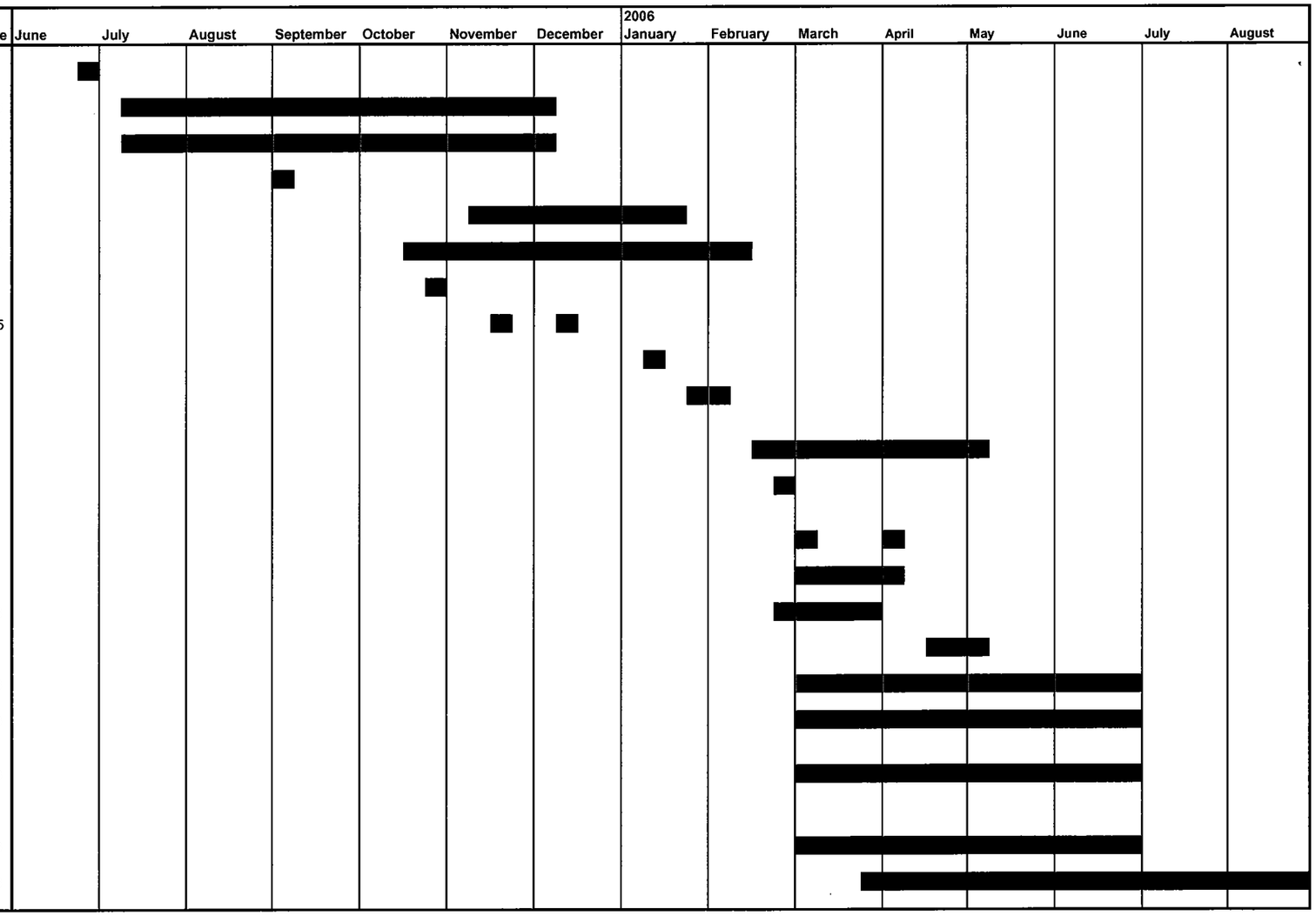
Josie Jaramillo
Chief Administrative Office

Each Commissioner

ESTABLISHMENT OF A SEPARATE PUBLIC HEALTH DEPARTMENT
IMPLEMENTATION TIMELINE

ATTACHMENT 8

#	Task Name	Department	Start Date	End Date
1	Adoption, in concept, of separate DPH		6/28/05	N/A
2	Implementation meeting/development of implementation plan	CAO	7/11/05	12/2/05
3	Development/drafting of amended ordinances	CC/DHR	7/11/05	12/2/05
4	Submission of 1st Progress Report	CAO	9/1/05	N/A
5	Development/drafting of Memorandum of Understanding (MOU)	DPH/DHS	11/10/05	1/19/06
6	Review of pharmacy issues/receipt of certifications & licenses	DPH/DHS/CC	10/15/05	2/10/06
7	Submission of 2nd Progress Report	CAO	10/27/05	N/A
8	Initial meetings with employee representatives/unions	DHS/DPH/CAO	11/17/05	12/12/05
9	Meeting with the Los Angeles Collaborative's Govenance Committee	DHS/DPH	1/11/06	N/A
10	Meetings with the Public Health, Mental Health, and Hospitals and Health Care Delivery Commissions	CAO/DPH/DHS	1/26/06	2/2/06
11	Meetings with employee representatives/unions	DHS/DPH/CAO	2/16/06	5/1/06
12	Board action on approval of new DPH/introduction of ordinances & MOU/ Public Comment		2/28/06	N/A
13	Adoption of ordinances & effective date of ordinances		3/7/06	4/6/06
14	Notice to employees regarding action/impact & informational meetings	DHS/DPH	3/7/06	4/6/06
15	Development/completion of AVRC MOU	DPH/AVRC/DHS	2/28/06	3/31/06
16	Reassignment of impacted employees/change of work location if needed	DHS/DPH	4/17/06	5/1/06
17	Follow-up ordinance changes	CC	3/7/06	6/30/06
18	Completion of issues such as methodology of cost allocations, HIPAA compliance issues, and dev. of add. MOUs with other County Departments	CAO/DPH/DHS	3/7/06	6/30/06
19	Finance/Budget Issues: - Bud. adj. to formalize creation of sep. roll-up budgets for DHS & DPH - Consideration of potential surpluses/deficits to the DHS & DPH budgets	CAO/DPH/DHS	3/7/06	6/30/06
20	Final implementation of DPH	DPH/CAO	3/7/06	6/30/06
21	Development/completion of DHS, DPH, DMH MOU	DHS/DPH/DMH	3/31/06	8/30/06



- Chief Administrative Office (CAO) managed actions
- Public Health (PH)/Department of Public Health (DPH) managed actions
- Department of Health Services (DHS) managed actions
- County Counsel (CC) managed actions
- General actions