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September 1, 2005

To: Supervisor Gloria Molina, Chair
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Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

PROGRESS REPORT ON ESTABLISHING A SEPARATE PUBLIC HEALTH DEPARTMENT

On June 28, 2005, your Board approved, in concept, a separate Public Health Department, and set October 18, 2005 as a preliminary target date to formalize the separation discussions. Further, your Board instructed my office, working with County Counsel and other affected County Departments, to develop a detailed implementation plan and timetable for establishing the new Public Health Department and to provide a 45-day progress report.

The attached report summarizes the issues discussed by a planning group, consisting of staff from the Department of Health Services (DHS), including Public Health, the Department of Human Resources (DHR), and my office, in regular meetings since your Board took its action. County Counsel, Auditor-Controller, and Chief Information Office staff have also participated in these meetings, as necessary. Subsequent meetings will include the Internal Services Department and other affected County Departments.

The issues discussed fall into four main areas: County Code changes, program issues, financing issues, and the allocation of administrative support staff between DHS and the new Public Health Department. Several policy questions, mentioned briefly below and in the attached report, will require further review; however, many of the issues related to the allocation of administrative support staff have been resolved.

Although October 18, 2005 had been tentatively identified as the target date to consider creating a separate Public Health Department, we recommend this issue be scheduled instead for the November 1, 2005 Board meeting. This change is proposed in light of

your Board's recent action to set October 18 as the date for the Beilenson Hearing to consider service changes at Martin Luther King, Jr./Drew Medical Center.

County Code Changes

County Counsel has reviewed the Los Angeles County Code to determine what changes will be required to separate the Public Health and Health Officer functions from the Department of Health Services. Generally, the ordinance changes that will be needed to implement this change fall into three categories: (1) new chapters; (2) substantive amendments; and (3) technical amendments.

In addition, the planning group is continuing to review a policy issue concerning the structure of the Director position within the Public Health Department; specifically, whether the County ordinance will reflect that the Director and Health Officer function are to be filled by the same person. The staff is surveying other jurisdictions to determine how they are structured and the advantages of each structure. Findings and a recommended approach will be provided to your Board in our next status report.

Drafting of the ordinance changes will depend on the resolution of this policy issue and other decisions still under review by DHS, Public Health and the planning group. We anticipate the ordinance changes will be prepared for consideration by your Board when this issue is placed on the agenda. The establishment of the new Public Health Department would be effective 30 days after final adoption of the ordinance changes.

Program Issues

The planning group discussed, in broad terms, the programs to be included in the separate Public Health Department, with the basic agreement that programs should be aligned as they are currently, unless there are strong reasons to move them. Discussions are being scheduled for DHS and Public Health senior managers to determine the programs which should remain part of the personal health services responsibility of DHS or become part of the separate Public Health Department. The initial proposal for the separate Public Health Department includes Public Health, the Office of AIDS Programs and Policy (OAPP), Alcohol and Drug Programs Administration (ADPA), and Children's Medical Services (CMS).

The planning group agreed that, once program recommendations have been finalized, it will be very important to execute memoranda of understanding (MOUs) between DHS and Public Health which ensure the continuation and enhancement of the integration of prevention activities into the delivery of personal health care services. Discussions are continuing on the specific areas to be incorporated into the MOUs, including shared

program areas, DHS and Public Health participation on internal and external planning and coordination groups, and services rendered to or received from other County Departments.

Financing Issues

The current DHS budget consists of a "roll-up" of the General Fund units, which include the Public Health program budgets, among others, and the Hospital Enterprise Fund budgets, which include, for example, the County hospitals. County funds are provided to DHS to meet statutory maintenance of effort (MOE) requirements, and funds above that amount are provided at the discretion of the Board. County funds provided to the Public Health budgets, even if they are established as a separate Department, will be included in the amount needed to meet the statutory MOE.

We will include, as part of the implementation plan to be considered by your Board, the necessary budgetary adjustments for DHS and Public Health to implement this change, if approved, during this fiscal year. Adjustments will include administrative positions and costs to be transferred from Health Services Administration (HSA) and other Public Health budgets to Public Health. The adjustments needed to formalize separate "roll-ups" for DHS and the new Public Health Department will be included in the 2006-07 Proposed Budget process in February/March 2006, to become effective July 1, 2006.

The planning group is continuing to review the potential fiscal impact of transferring administrative support positions and costs to a new Public Health Department and changes in the DHS allocation of centralized administrative costs or "HSA overhead" to the other DHS operating budgets. HSA overhead costs which will no longer be billed to the Public Health budgets will be shifted to the remaining DHS budgets, primarily the Enterprise Hospitals.

The planning group is also continuing to review the potential financial impact of other issues, including discounts from bulk purchases currently shared by both DHS and Public Health as a single Department, which either may not be available or may need to be modified with the creation of a separate Public Health Department.

Public Health Management Infrastructure and Administrative Support

To determine the administrative staffing needs for a new Public Health Department, the planning group reviewed the existing staffing and workload for the major administrative support areas within DHS and projected the staffing and workload needs for the new Department. Support areas included: Human Resources; Contracts and Grants/Contract Monitoring; Finance/Materials Management; Communications,

Governmental Relations, and Planning; Audit and Compliance; Risk Management/Quality Assurance; Facilities and Space Management; Information Systems/Information Technology; and Capital Projects.

While some issues are still under discussion and dollar estimates need further refinement, the planning group estimates that the separate Public Health Department will require 161.0 positions to perform centralized support functions, consisting of 138.0 existing positions transferred from HSA and 23.0 new budgeted positions. A portion of the estimated cost of $1.6 million (salaries and employee benefits) for the new positions may be offset by Public Health program revenue. The number of support positions may be revised somewhat based on further discussions by the planning group.

Implementation Plan and Timeline

Once decisions are made regarding the programs to be included in the new Public Health Department, the consolidation or potential relocation of administrative support staff, and other pending issues, the planning group will finalize a detailed timeline for all of the actions needed to establish the new Public Health Department. We will provide your Board with a second progress report by October 14, 2005, including recommendations on issues still to be resolved.

The new Public Health Department, if approved by your Board, would become effective 30 days after final adoption of the ordinance changes and is expected to be fully implemented by April 2006, with separate budget roll-ups by July 1, 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

Attachment

c: Executive Officer, Board of Supervisors
County Counsel
Auditor-Controller
Chief Information Officer
Director of Health Services
Director of Internal Services
Director of Personnel

PROGRESS REPORT ON ESTABLISHING A SEPARATE PUBLIC HEALTH DEPARTMENT

On June 28, 2005, the Board of Supervisors approved, in concept, a separate Public Health Department and set October 18, 2005 as a preliminary target date to formalize the separation discussions. Further, the Board instructed the Chief Administrative Office (CAO), working with County Counsel, the Department of Health Services (DHS), and other affected County Departments, to develop a detailed implementation plan and timetable for establishing the new Public Health Department. The Board also requested that the CAO, with County Counsel and the Director of Personnel, provide a 45-day progress report.

A planning group consisting of staff from CAO, DHS (both Health Services Administration and Public Health Services), and the Department of Human Resources (DHR) met regularly to detail issues and implementation steps which must be addressed if a new Public Health Department is created. Areas discussed include relevant County ordinance changes, program issues, financing issues, and proposed administrative staff changes. County Counsel, Auditor-Controller, and the Chief Information Office staff have also participated in these meetings, as necessary. Subsequent meetings will include Internal Services Department staff and other affected County Departments.

A second progress report will be provided to the Board by October 14, 2005, including a proposed timeline and draft organizational charts.

County Code Changes

County Counsel has reviewed the Los Angeles County Code to determine what changes will be required to separate the Public Health and Health Officer functions from the Department of Health Services. Generally, the ordinance changes that will be needed to effectuate the change can be grouped into three categories: (1) new chapters; (2) substantive amendments; and (3) technical amendments.

The first category, new chapters, will involve additions to Titles 2 (Administration) and 6 (Personnel) of the Code. Specifically, Chapter 2.77 will be added to create the Department of Public Health. This chapter will detail the functions of the new Department, similar to that which currently exists for the Department of Health Services under Chapter 2.76. Likewise, Chapter 6.77 will be added to accommodate Public Health related personnel items that must be removed from Chapter 6.78, relating to the Department of Health Services.

The second category, substantive amendments, will involve deleting provisions from Chapter 2.76 that are no longer necessary in light of the creation of the Public Health Department. For the most part, this work will involve deleting any references to the

Health Officer function, as well as all references to Public Health functions and transferring those functions to the Public Health Department's new ordinance.

The third category, technical amendments, will involve updating statutory and legal references found throughout current, various chapters in Titles 2, 8, 10, 11 and 12, as well as repealing any provisions that are no longer operable or relevant.

Health Officer Function

Under existing state law, it is not a legal requirement that the Director of Public Health also be the Health Officer. The Health Officer must be a graduate of a medical school while the Director need not be. The Board has the discretion to combine the two positions or separate them.

The planning group is continuing to review this policy issue of whether the County ordinance will reflect that the Director and Health Officer function are to be filled by the same person. The staff is surveying other jurisdictions to determine how they are structured and the advantages of each structure. Findings and a recommended approach will be included in the subsequent report to the Board.

Drafting of the ordinance changes will depend on the resolution of the policy issue mentioned above, as well as other decisions still under review by DHS, Public Health and the planning group. It is anticipated that the ordinance changes will be prepared for consideration by the Board when this issue is placed on the Board's agenda.

Program Issues

The planning group discussed, in broad terms, the programs to be included in the separate Public Health Department, with the basic agreement that programs should be aligned as they are currently, unless there are strong reasons to move them. Further discussions are being scheduled for senior managers in DHS and Public Health regarding the programs which should remain part of the personal health services responsibility of DHS or become part of the separate Public Health Department. These recommendations will then be explored further by the planning group. As indicated in the CAO's June 9, 2005 report, the initial proposal for the separate Public Health Department could include Public Health, the Office of AIDS Programs and Policy (OAPP), Alcohol and Drug Programs Administration (ADPA), and Children's Medical Services (CMS).

Memoranda of Understanding (MOUs)

The planning group agreed that, once recommendations have been finalized regarding the programs proposed for the separate Public Health Department, it will be very important to execute memoranda of understanding (MOUs) between DHS and Public Health which ensure the continuation and enhancement of the integration of prevention activities into the delivery of personal health care services. Discussions are continuing

on the specific areas to be incorporated into the MOUs, including instances where both DHS and Public Health participation on internal planning and coordination groups must be maintained. Also being addressed is County participation on external healthcare groups, where it may be appropriate for DHS to continue as the County representative, for Public Health instead to become the County representative, or for both DHS and Public Health to participate in an official capacity.

Further, there are shared program areas, e.g., the Public Health Library, pharmacy services, and laboratories, where services and responsibilities will need to be addressed specifically in the MOUs, irrespective of whether the programs remain part of DHS or become part of the Public Health Department.

Finally, staff is reviewing existing MOUs between DHS and other County Departments to determine where revisions may be needed and/or where new MOUs will be needed to delineate the responsibilities of DHS and Public Health in providing services to or receiving services from other County Departments.

Financing Issues

The current DHS budget consists of a "roll-up" of 12 operating budgets and four non-operating budgets. The 12 operating budgets include seven General Fund budgets and five Enterprise Hospital Fund budgets. General Fund budgets are: Health Services Administration (HSA); Office of Managed Care (OMC); Public Health; OAPP; ADPA; Juvenile Court Health Services (JCHS); and CMS. Enterprise Fund budgets are: LAC+USC Healthcare Network (LAC+USC Medical Center; comprehensive health centers and health center); Coastal Area (Harbor/UCLA Medical Center; comprehensive health center and health centers); San Fernando Valley Area (Olive View/UCLA Medical Center; High Desert Multi-service Ambulatory Care Center (MACC); Antelope Valley Rehabilitation Center; comprehensive health center, health centers and school-based clinic); Southwest Area (Martin Luther King, Jr./Drew University Medical Center; comprehensive health center and health center); and Rancho Los Amigos National Rehabilitation Center.

The four non-operating budgets are: Tobacco Settlement Programs (budgeted Tobacco Settlement funds not yet allocated to specific program uses), Health Care (intergovernmental transfer or IGT funds needed to draw down SB 855 Disproportionate Share Hospital funds), Realignment (Realignment Sales Tax revenue); and Contributions to Hospital Enterprise Funds (County funds allocated to the DHS Enterprise Hospital budgets).

County funds are provided to DHS to meet statutory maintenance of effort (MOE) requirements, and funds above that amount are provided at the discretion of the Board. County funds provided to the Public Health budgets, even if they were established as a separate Department, will be included in the amount needed to meet the statutory MOE.

If the Board approves the creation of a separate Public Health Department to be effective during 2005-06, the CAO, DHS and Public Health will finalize the budgetary adjustments which will need to be put in place for this to move forward in 2005-06.

Currently most centralized administrative costs from HSA are billed to the other DHS operating budgets as "HSA overhead." If the new Public Health Department is created, it is anticipated that the Public Health budget will be adjusted to include centralized administrative support staff and directly billed costs for the new Public Health Department, as discussed further below. This will replace the general HSA overhead amounts currently billed to the Public Health budgets. Those HSA overhead costs will be shifted to the remaining DHS budgets, primarily the Enterprise Hospital budgets.

Adjustments will be made to reflect the transfers, if any, of administrative positions from the other Public Health budgets if they are moved to centralized support units within Public Health. Adjustments will also be needed in the HSA budget to reflect the transfer of costs and administrative support positions to Public Health.

The planning group is continuing to review the specific impact of this shift in HSA overhead costs on State and federal revenues in the Public Health budgets and on Medi-Cal revenues in the Enterprise Hospital budgets. The Medi-Cal revenue analysis will depend on final resolution of issues related to the Medi-Cal Redesign. The allocation of County funds and Realignment Sales Tax will be adjusted accordingly to balance the 2005-06 DHS and Public Health budgets.

No impact is expected for specific program revenues since they will remain aligned as they are currently under the operating budget structures. This includes special funds and trust funds currently associated with specific programs. Further, no impact is expected on the allocations of Measure B Special Tax revenues and Tobacco Settlement funds, which are approved on a program by program basis by the Board and will continue to be allocated on this basis.

The budgetary adjustments needed to formalize the creation of separate "roll up" budgets for DHS and the new Public Health Department will be included in the 2006-07 Proposed Budget process in February and March 2006, including any necessary adjustments to eCAPS. The specific operating budgets which will be recommended for inclusion in the new Public Health Department will depend on the outcome of the current program discussions between DHS and Public Health senior managers and further review by the planning group. The non-operating budgets are expected to remain part of the DHS budget.

Increases in operating costs and, given the projected Health Services fiscal deficit, potential curtailments will be considered as part of the 2006-07 budget process, with the difference that the Public Health Department will submit recommendations directly to the CAO, rather than being incorporated into the DHS budget request. CAO staff will then develop recommendations based on their reviews of the DHS and Public Health

Proposed Budget submissions, including the recommended allocation of additional County funds, e.g., increases in County funds and increases in Realignment Vehicle License Fees.

The planning group is reviewing the issue of how to address potential year-end savings from the new Public Health Department. Currently, such amounts from Public Health budgets are transferred to the Health Services designation.

Further, the planning group is continuing to review the potential financial impact which may result from separating the DHS and Public Health operations, including discounts from bulk purchases currently shared by both DHS and Public Health as a single Department, which either may not be available or may need to be modified with the creation of the new Public Health Department.

Public Health Management Infrastructure and Administrative Support

In order to determine the administrative staffing needs for a new Public Health Department, the planning group conducted a series of meetings to review the existing staffing and workload for the major administrative support areas within DHS, including Public Health programs, and the projected staffing and workload needs for the new Department. In these meetings, the group discussed staffing models which the participants felt would best serve the operational needs of both the new Department and of DHS, while acknowledging the current funding restrictions.

The group recognized that the existing DHS infrastructure is not, in some areas, fully staffed to meet existing workload needs, as a result of administrative curtailments to meet System Redesign savings targets. This was taken into consideration in reviewing the numbers of positions to be transferred to a new Department and where new positions will be needed. The discussion below presents the planning group's current proposals for staffing changes, if the Board approves the establishment of a new Public Health Department.

Based on these discussions, the preliminary assessment is that the new Public Health Department will need 161.0 positions to perform centralized administrative support functions, including 138.0 existing positions which will be transferred to the new Public Health Department from HSA. An additional 23.0 budgeted positions will be needed at an estimated cost of $1.6 million for salaries and employee benefits. Much of this additional cost may be offset by revenue from the Public Health programs. The number of support positions needed may be revised somewhat based on further discussions by the planning group. All transferred and new positions will be reviewed by DHR staff to ensure that the appropriate classifications are allocated to the new Department.

Public Health will be identified as the central administrative budget, just as HSA is for DHS, incorporating the senior management and centralized administrative support functions for the new Public Health Department. It is anticipated that the existing Director of Public Health position will be established as the Director of the new Public

Health Department. In addition, new positions will include: a Chief Deputy, a Secretary for the Chief Deputy, and a Special Assistant for the Director of Public Health. The new functions of Administrative Deputy and Chief Financial Officer will be addressed by transferring existing positions from HSA to Public Health, which were included in the administrative consolidations. The planning group is continuing to review the proposed organizational structure for the new Public Health Department with the creation of centralized support units in Public Health. The organizational charts will be finalized, pending further discussion on programs to be recommended for the new Public Health Department, and will be included in the next progress report to the Board. CAO and DHR staff will also work with DHS to review the affected units in HSA to address any potential organizational or classification issues.

In discussing the allocation of existing administrative support positions in DHS/HSA to a new Public Health Department, it was agreed that administrative support positions, which were transferred from Public Health to HSA as part of the administrative consolidations, would be transferred back to Public Health. Further, positions which are identified as currently providing administrative support solely to Public Health operations will also be transferred to the new Public Health Department.

In instances where positions are identified as providing administrative support for only a portion of the time, estimates were developed to determine the number of full-time equivalent (FTE) positions providing administrative support to Public Health, which will be transferred to the new Department.

Regarding potential impact on employees, it is expected that employees who are currently filling positions performing duties entirely related to Public Health operations will be reassigned to the new Department. Where employees are in positions performing duties only partly related to Public Health, letters will be sent to affected employees asking whether they are interested in reassignment to the new Public Health Department. The final decision on employee reassignments will be made by senior management at DHS and Public Health. All proposals affecting represented employees will be discussed with union representatives.

Filling the new positions needed for the new Department will be handled using the same process currently used for filling vacant positions in County Departments.

Human Resources

It was determined that separate Human Resources operations should be established for DHS and the new Public Health Department in order to best meet the operational needs of each Department. A total of 17.0 FTEs in HSA were identified as supporting Public Health operations, several of which had been part of the Public Health budget prior to the administrative consolidations and will be transferred back to Public Health. An additional 20.0 positions are proposed to support Human Resources activities in the new Public Health Department. These new positions will be assigned to the classification; examinations; payroll; operations; leave management; employee

relations; and workers' compensation units. This will leave 283.0 budgeted positions in HSA, per the 2005-06 Adopted Budget, to support Human Resources operations for DHS.

There are areas within the Human Resources operations, as well as others discussed below, where Public Health may not elect to add staff, but may instead choose to have DHS provide the services. All instances where services would be provided by either DHS or Public Health will be reflected in the MOUs between the two departments. For example, Public Health may not elect to have separate staff for: Item Management (may contract back with DHS, who currently maintains the system); security services (may contract directly with Office of Public Safety, as DHS currently does); Advocacy services (may contract directly with DHR, as DHS currently does); Equal Employment Opportunity Commission issues (may contract directly with the Office of Affirmative Action Compliance, as DHS currently does). An area identified as requiring further discussion is civil litigation.

Contracts and Grants/Contract Monitoring

It was determined that a separate Contracts and Grants unit should be established for the new Public Health Department. Thirteen FTEs are proposed for transfer from DHS to Public Health, some of which currently work exclusively on Public Health contract issues. Based on preliminary discussions, no new staff will be required. This will leave 38.0 positions in HSA, per the 2005-06 Adopted Budget, to support Contracts and Grants operations for DHS.

The allocation of Contracts and Grants positions for Public Health was based on the estimate from Contracts and Grants staff that approximately 23 percent of staff time during the period reviewed related to Public Health agreements. Most ADPA and OAPP contracts development is handled by staff in those departments.

It was determined that a separate Contract Monitoring unit should be established for the new Public Health Department. Twenty-two FTEs are proposed to be transferred from HSA, which includes a number of positions assigned full-time to provide fiscal monitoring of Public Health contractors and several positions working at least part of the time on administrative monitoring for Public Health. Based on preliminary discussion, no new positions will be needed. This will leave 17.0 budgeted positions in HSA, per the 2005-06 Adopted Budget, to support Contract Monitoring operations in DHS. The Department of Health Services indicates that this is an area where further review is necessary to determine whether additional positions may be needed to meet the Board's directives regarding contract monitoring.

In finalizing the proposed centralized Contracts and Grants and Contract Monitoring units in Public Health, the existing staffing in the Public Health budgets will also be reviewed for potential consolidation to some extent in the centralized unit in Public Health.

Finance/Materials Management

It was determined that a separate Finance unit should be established for the new Public Health Department. As part of the administrative consolidations, Finance positions were transferred to HSA from Public Health. The positions remained in a separate unit in order to ensure proper tracking of administrative costs claimed to the various grant and revenue programs in Public Health, and these positions will be transferred back to Public Health. Based on preliminary discussions, 58.0 budgeted positions will be transferred from HSA and no new positions will be needed. This will leave 357.0 budgeted positions in HSA, per the 2005-06 Adopted Budget, to support Finance operations, including the Consolidated Business Office (CBO), in DHS.

There are some areas in Finance where either the new Public Health Department or HSA may elect to contract back with the other to provide administrative support, e.g. eCAPS support (Public Health with HSA) or invoice processing (HSA with Public Health). This is an area where additional discussions are scheduled, since both HSA and Public Health may elect to contract for some support services with another central service County Department under the shared services model.

Further discussion will also consider the staffing in the separate finance units in Public Health, ADPA, OAPP and CMS, for potential consolidation to some extent in the centralized unit in Public Health.

Of the 58.0 budgeted positions identified for transfer to Public Health, five are in the Materials Management unit. It was determined that a separate Materials Management unit should be established for the new Public Health Department. Based on preliminary discussions, no new staff will be required. The existing staffing in the Public Health budgets who may be involved with Materials Management will also be reviewed for potential consolidation to some extent in the centralized unit in Public Health.

Communications, Governmental Relations, Planning

Further discussion will be scheduled to determine whether and to what extent separate units should be established for the new Public Health Department for Communications, Governmental Relations and Planning. The issues discussed below are based on preliminary discussions by the planning group.

External Relations: As part of the administrative consolidations, the HSA and Public Health Communications offices were consolidated. The consolidated office receives the initial calls from the media for Public Health, but Public Health-related calls received by the unit are forwarded to the Director of Public Health and the Chief of Operations, Public Health to determine which Public Health units can respond. Press releases for Public Health are finalized and issued by the consolidated communications office, but generally drafted by Public Health. Several Public Health units have staff, whose duties include work on external communications and Public Health maintains the grant-funded

Bioterrorism Risk Communications unit. HSA estimates that approximately 90 percent of the work handled by the HSA External Relations unit relates to the County hospitals.

A major issue for DHS in this area is the potential need to address shared media equipment, particularly graphics capability recently purchased in large part with Bioterrorism Preparedness funds. To some extent, it may make sense to continue to share use of the equipment and contiguous space, but that will be determined with further discussions. As an interim measure, DHS and Public Health may continue to operate with separate staffing in shared space.

Governmental Relations: It appears that the workload handled by the four staff in the office is split evenly between Public Health and DHS, although most of the legislative analysis on Public Health issues is performed by Public Health program staff. The Governmental Relations unit is charged primarily with central coordination of legislative review and in resolving issues that arise when different programs within DHS may have conflicting points of view and recommend conflicting County positions. Given the existing staffing level at HSA, it may not be feasible to divide the staff. Leaving the HSA Governmental Relations unit intact will require adding at least one additional position in Public Health as the point person for legislative coordination. This area will be discussed further, including review of existing staff in Public Health programs currently involved in legislative analysis.

Planning: Much of the work currently performed by the HSA Planning unit relates to County hospital operations and initiatives, although staffing needs for both personal health and public health have grown with implementation of the Performance Counts! Program Budgeting/Strategic Plan effort. Further discussion will be scheduled to determine the need for a separate planning unit in the new Public Health Department, potentially involving transfers of existing positions and/or the addition of new positions.

Some planning activities are already occurring in Public Health programs (OAPP, ADPA, CMS), and further discussion will determine the extent to which these activities can also be centralized in the new Department. Because of the interactive nature of the relationship between the HSA and Public Health planning efforts, with the HSA Planning Unit in particular dependent on Public Health for data, this is an area that will need to be addressed in the MOU between the two Departments.

Audit and Compliance

It was determined that, for the most part, a separate unit would not need to be created in the new Public Health Department, and no staff will be transferred from DHS to Public Health. This will leave 37.0 budgeted positions in HSA, per the 2005-06 Adopted Budget, to support Audit and Compliance activities for DHS.

The Audit and Compliance Division within DHS is comprised of four units: Audits, Investigations and Medical Malpractice (A/I); Information Systems and Contracts; Health Authority Law Enforcement Task Force (HALT); and Compliance and Legal/Contract Compliance.

Rather than establish a separate unit, it was determined that the best approach may be for the new Department to make arrangements with the Auditor-Controller to handle their audits. This was based on the existing heavy workload of the A/I unit within DHS and the projected workload needs for Public Health. The preliminary estimate from Auditor-Controller staff is that the workload may require 1.0 additional FTE. This position is not included in the estimate above for new staffing needed, but will be reflected in the estimates for additional services and supplies costs from other County Departments.

The Compliance unit deals primarily with hospital Medicare and Medicaid requirements and the current workload deals only minimally with Public Health programs. Therefore, no positions are proposed for transfer to Public Health, and the unit will remain intact at HSA.

The HALT unit will remain at HSA, since very little of the workload is related to Public Health. The HALT unit currently has an MOU with the Sheriff's Department and the Los Angeles Police Department for deputies and officers who participate in HALT activities.

Risk Management/Quality Assurance

It was determined that most of the Public Health related workload handled by the current Risk Management/Quality Assurance unit in DHS involved employee relations issues, rather than the clinical issues which constitutes most of the workload from hospitals and health centers. The Public Health workload appears to comprise only a minor portion of the unit's current workload, with an estimate of approximately 0.2 FTE. Therefore, no positions will be transferred from DHS to Public Health. It is expected that the new Department would make arrangements to have the DHS unit continue to provide the services or to engage in discussions with CAO Risk Management, for example, on a potential shared services model.

Facilities and Space Management

It was determined that a separate Facilities Unit should be established for the new Public Health Department, while certain functions in this area would continue to be shared by both DHS and Public Health. It is proposed that 25.0 positions be transferred from DHS to Public Health, including some positions which were transferred from Public Health as part of the administrative consolidations. One new item will be added as the Facility Manager for the new Public Health Department to handle their lease agreements. This will leave 35.0 budgeted positions in HSA, per the 2005-06 Adopted Budget, to support Facilities and Space Management activities for DHS.

The DHS Facilities Management Division includes 60.0 budgeted positions and performs the following functions: day to day activities, such as routing incoming phone calls, mail and payroll activities; technical issues related to phone and cell phone use; custodial services for eight health centers and HSA; building and crafts needs for the facilities; and lease agreements. Some of the custodial services positions are currently assigned exclusively to Public Health areas and will be included in the positions transferred to the new Department.

Once program issues have been resolved, the planning group will conduct a more detailed review of space needs for DHS and Public Health, including what administrative functions should be consolidated or moved from the DHS Headquarters and other shared space. At this point, it is expected that the senior management for both DHS and Public Health will continue to be based at DHS headquarters. With respect to the issue of "proprietor tenant" as the landlord and "tenant" in shared spaces, the CAO's basic guideline is to consider as "proprietor" the County Department which utilizes the majority of the space. This issue, as well as the methodology for cost allocation, will be determined for all shared space in subsequent planning group meetings.

For Building and Craft services, Public Health currently receives services from the hospital facilities staff located in closest proximity to the Public Health site. The planning group will have further discussions on whether and how to continue this relationship, as well as the potential for seeking these services from ISD, where appropriate. Either decision will result in the need for negotiations between Public Health and the hospitals or ISD to provide these services, and these arrangements will need to be reflected in the MOUs.

Information Systems (IS)/Information Technology (IT)

Because both DHS and Public Health currently maintain separate IS units and IT systems, it was determined, at least initially, that both units should maintain operations as they currently exist. Where HSA systems support Public Health or Public Health systems support HSA, billing mechanisms will be developed and systems descriptions will be incorporated into the MOUs.

Public Health has many IT applications, software, and systems that relate specifically to their mission, and Public Health budget units, such as OAPP, CMS, and ADPA, have their own IT staff budgeted. Many IT systems within the Department are currently operated by DHS/HSA IT staff, who provide service/data to/for Public Health, as well as the other parts of DHS. IT infrastructure issues operated/maintained by DHS/HSA would be costly to duplicate for Public Health, and that is not, therefore, being considered at this time. Areas of concern, which are not directly related to IT functions, such as Health Insurance Portability and Accountability Act (HIPAA) security, need to be addressed to determine if a separate administrative unit should be established in Public Health, or services continue to be provided by DHS and charged to Public Health directly as another County department.

Examples of areas where services are provided by either DHS or Public Health to the other department include: e-mail and other communications services, where both DHS and Public Health IT staff provide support services for various DHS and Public Health units; Website/Internet, where several positions support Website/Internet sites for both DHS and Public Health; Networking Services, where in some locations, Public Health is responsible for and maintains data lines up to the wall jack, while HSA provides support services for computers; and Application Development, where, for example, the DHS Human Resources system, Item Management, is totally supported by HSA staff, but the application is utilized by all of the Public Health programs.

The planning group is continuing to review DHS and Public Health IT operations to determine staffing and services provided, and will discuss further a shared services model which could be developed with ISD. In addition, areas to be addressed are: process for addressing future systems needs for both DHS and Public Health; and potential issues regarding sharing of Protected Health Information (HIPAA related)/medical records where patients are treated/seen in public health clinics and/or DHS hospital/clinic, and where it is necessary to refer to the public health record/medical record, where applicable, for the patient's treatment/follow-up.

Capital Projects

Based on the current workload, it was determined that it may not be necessary to establish a separate Capital Projects unit in the new Public Health Department, and therefore no staff will be transferred from DHS to Public Health. Based on further discussions, it may be necessary to add one additional position to coordinate Capital Projects issues for Public Health, but initially it is expected that those responsibilities will be handled on a part-time basis by existing Public Health staff. This will leave 12.0 budgeted positions in HSA, per the 2005-06 Adopted Budget, to support Capital Projects functions for DHS.

There are currently 22 Public Health capital projects with a total estimated cost of $19.9 million. Of that amount, $15.2 million is for the new Public Health Laboratory. It is estimated that 1 FTE will be needed to manage all of the Public Health capital projects; however, in recognition of the peaks and valleys in the volume of Public Health capital projects, it was determined that the best option initially will be for Public Health to have HSA staff continue to provide services to Public Health on a per project basis via an MOU.

Implementation Plan and Timeline

Once decisions are made regarding the programs to be included in the new Public Health Department, the consolidation or potential relocation of administrative support staff, and other pending issues, the planning group will finalize a detailed timeline for all of the actions needed to establish the new Public Health Department.

Although October 18, 2005 had been tentatively identified by the Board as the target date to consider creating a separate Public Health Department, the CAO is recommending this issue be scheduled instead for the November 1, 2005 Board meeting, in view of the Board's recent action to schedule a Beilenson hearing on October 18, 2005 to consider health services changes.

It is expected that the establishment of the new Public Health Department, if approved by the Board, will become effective 30 days after final adoption of the ordinance changes and is expected to be fully implemented by April 2006. Budgetary changes to the departmental roll-ups will be effective July 1, 2006 for the 2006-07 Budget. A second progress report will be provided to the Board by October 14, 2005, including recommendations on issues still to be resolved as of this status report.