Collaborative Service Area Questions and Comments

September 22, 2020

The following comments were received between September 15-21, 2020. This feedback will be considered as we finalize the CSA map for the FFY22 WIC RFP.

1. I have concerns about combining services of very poor rural areas with much wealthier high need districts. I work and live in rural Iowa and we have seen considerable loss of public service to those that are most in need. We have already lost access to mental health and workforce services in our communities. This would be another loss in areas like Decatur, Ringgold, and Taylor counties. I think it would be better suited to increase the size of our regions combining more like counties and service providers that understand the needs of our communities. Combine areas such as Dallas and Polk that understand the needs of an urban community to target services local. Allow rural areas to work with other agencies to provide an inclusive and intensive access to multiple services to overcome the cycle of poverty.
2. I wanted to provide comment on the collaborative service area. I first want to commend the department on the tremendous undertaking and surely lots of work that went into (and will continue) to go into this process. Having worked in these programs for many years, streamlining these projects will allow for such robust collaboration and leveraging of resources that it will no doubt have a positive impact for best serving these marginalized populations. I fully support the idea of developing collaborative service areas. I would encourage a second look at the counties that comprise each area and further consideration of the Children's Behavioral Health system that is being created in the Mental Health and Disability Service Regions.
3. Thank you for the opportunity to provide feedback regarding the MCAH collaborative service areas proposed for October 2023. A few thoughts… I do not see that the data provided during the IDPH presentation supports the claim that the model would improve service delivery for clients. I do see how it might simplify administration of the grants for the state.

	However, I foresee that the administration of the program could be very complicated for local grantees, crossing multiple jurisdictions and potentially coordinating many subcontracts to cover the increased service area. This management has the potential to be labor-intensive, and could eat up precious grant funds that may be better spent on client services and program activities. Funding for MCAH has long been heavy on "in-kind' contributions and depended on agencies to generate their own program income to function. This could present a problem for grantees that are local government agencies whose in-kind contributions are from the tax revenues of the agency's home jurisdiction. These may not be available to cover costs outside the jurisdiction. Further compounding the MCAH model of "bring-your-own-funding" is the difficulty collecting program income from Medicaid MCO's within the screening center provider types. The process has been wrought with denials and difficulties; no one has been able to help or correct the issues, despite agencies reaching out for assistance and support in a variety of ways. We have even paid for a professional billing company to try to figure this out for us to no avail. The amount of unpaid expenses to agencies is real and significant. I envision that it could be even more difficult to cover costs when sending staff out to cover a larger service area. Without a solid revenue source, the additional cost to operate satellite clinics and expand staffing is even more concerning. It is worth questioning whether or not the model makes sense fiscally. If it were not for the MCAH populations being a priority to us and a value for preserving the MCAH infrastructure we have built thus far, why would anyone apply for this? Overall I feel this models adds complexity to what is already our ***most complex*** contract with IDPH, and would not improve service to clients.
4.	It would be greatly beneficial for ECI areas to align with the proposed new service areas. I would like to see Adair County included in service are 5. This will assist the communication and planning in the 4 R Kids ECI area.
5.	I recently received and reviewed the intended Collaborative Service Area proposal. As the CEO of the Southeast Iowa Link (SEIL) Mental Health and Disability Service Region, I want to identify and acknowledge the strong partnerships that have been forged with the local WIC, Maternal, Child, and Adolescent Health (MCAH), I-Smile™, and 1st Five provider agencies in our 8 county region. MHDS Regions have been tasked with creating local Children's Behavioral Health services which includes in structure a Children's Advisory Committee. The professionals that work in these service areas have been a tremendous source of information and an active partner in identifying how to improve the health and wellbeing of children and families in our area. I have great concern that with a transition to the indicated Collaborative Service

Areas, there will be a fracturing of those established working relationships and the foundations that have been built via the efforts of our collective provider agencies, PCPs, childcare providers, AEAs, and Schools. This would be considered a major set back to the work that has been done locally in our region.

With the above indicated reasons in mind, I respectfully request that consideration be given to aligning the Collaborative Service Areas with the same geography of the Mental Health and Disability Service Regions.

Thank you for your attention and in the event that there is anything further I can contribute to the discussion/planning, I am happy to participate.

6. A. What kind of timeline should be expected for issuance of RFP to Notice of Intent to Award? For FFY2021 IDPH issued the initial RFA in March, applications were due in May, and awards in July; a total of (4) months. If this timeline is not expanded, and the chosen contractor decides to service the region with their local staff, the potential exists for the remaining counties to have to add/reduce staff in a 60 day time frame. Consideration should be given to timing of the RFP and how it will affect agencies.

   B. Many agencies supplement their Fluoride Varnish programs with funds from ECI. Are we expected to cover fluoride varnish in the collaborative service areas? The local ECI Boards do not have the same service areas as the proposed collaborative service area for WIC/MCAH/1st Five nor does the timing of the ECI RFP coincide with MCAH/1st Five. ECI funding is typically awarded in June with start date of July 1st.

   C. Are agencies expected to contact current WIC/MCAH/1st Five contractor holders to review how the programs work in their counties or will IDPH provide additional information to all counties identified in the collaborative service area? For example, does the current contractor holder subcontract with other providers or use their own staff? What are current staffing levels? How many days a month is WIC in your county? How much funding has been awarded to the contract holders in the past? How much Title XIX revenue is generated? Do you have barriers in providing services?

   D. Is there a plan to assist 1st Five coordinators in sharing information about the service area changes with the medical providers with whom they have worked tirelessly to form trusting relationships?

   E. Will guidance be given on how to work with medical providers who are unwilling to continue to work with 1st Five due to the frequent changes in services, messaging, and now staff and site changes?

7. I have recently become aware of the proposed Collaborative Service Areas to be established by the Iowa Department of Public Health. I would like to begin by

commending the IDPH for prioritizing collaborations among regional programs and groups. In our rural culture, we have found the work to be more effective when communicated and shared among a broad array of stakeholders. This has been especially true with the Mental Health/Disability Services regions in the past five years. For this reason, I would like to respectfully suggest that the IDPH consider aligning the Collaborative Service Areas with the MH/DS Regions. As the regions assume more responsibility for children's behavioral health, I believe that the strong network of public health providers will be tremendous partners to the regions, and alignment of the areas will be most beneficial.

As the CEO, I look forward to strengthening our partnerships with local WIC, Maternal Health, Adolescent Health and the 1st Five providers in our region. We have a strong commitment to collaboration and partnership in the East Central Region, so I am looking forward to their growing input for the wellbeing of children and families in our area.

Thank you in advance for your consideration and please me know if there is anything I can do to assist.

8. As the medical director of the [County] County Board of Health I am opposed to having a collaborative service area under [Agency] based on past negative experiences since [County] County was previously neglected by them with inadequate services provided. If you would like to know the details of this, please speak with our public health nurse, [Name], [Phone Number].