Collaborative Service Area Questions and Comments

September 30, 2020

The following comments were received between September 22-29, 2020. This feedback will be considered as we finalize the CSA map for the FFY22 WIC RFP.

1. West Central Community Action values our longstanding relationship.with the Iowa Department of Public Health as we collaborate to serve children and families in western Iowa. We offer the following comments and concerns regarding the new WIC, MCAH, I-Smile, 1st Five Proposed Collaborative Service Areas. While we understand the need for consistency and quality across the state, our main concern is how the proposed Regions would be realigned and divided. West Central Community Action provides multiple services to ten counties in Southwest Iowa, and we serve eight of those counties with the WIC program. The new proposed map divides our current service area in half (four counties in Region 2 and four counties in Region 3).

   West Central Community Action's top concerns and questions include:
   - The current regions do not align with our service area, which causes issues when providing bundled services to families such as LIHEAP, Head Start/Early Head Start, Outreach services, Weatherization, and FaDSS.
   - Services to families will be interrupted by the new changes because families in many counties will be required to work with new service providers.
   - West Central Community Action has established community partnerships that provide additional and enhanced services to WIC families. The proposal fractures existing service areas and will disrupt existing supportive partnerships.
   - West Central Community Action is concerned that it will compete with other Community Action Agencies for overlapping service territories.
   - Did the Iowa Department of Public Health request input from service recipients, current providers, or other community stakeholders before releasing the proposed changes?
   - West Central Community Action is concerned about the proposed timeline. An aggressive timeline will adversely impact smooth transitions to new providers.
   - West Central Community Action has consistently delivered high-quality WIC services for many years. Numerous clients over the years have provided

feedback that our services and staff provide services at the highest level. We want to continue to provide high-quality services to all eight of our current counties. However, as we look at the proposal, it appears we will be in the position of having to determine which region we most wish to continue to serve.

- Please clarify if the winning respondents will receive a one year contract or a multiple-year contract.
- West Central is concerned that the process will result in lost jobs across the state. Job stability during a pandemic is essential for staff, many of whom have been with the program for years.
- Since subcontracting will be allowable, how will current goals, objectives, and Focus reports will be implemented across multiple WIC agencies?

Possible Alternatives:

- West Central Community Action asks the Iowa Department of Public Health to consider redesigning the regions with fewer disruptions to Community Action Agency service areas across the state. While not all WIC providers are Community Action Agencies, many are current providers, and aligning services that more closely mirrors Community Action Agency service areas would cause less disruption to the service network across the state. Region 2 and 3 could be divided vertically instead of horizontally.
- West Central Community Action Agency suggests that MCAH, I-Smile, and 1st Five territories could be combined while leaving the current WIC service area intact.
- As an alternative to redistricting, West Central Community Action Agency believes establishing a statewide referral process, and Memoranda of Understanding between programs would increase service opportunities and be far less disruptive than the current proposal.

2. MCAH, WIC, and First Five by one provider will make it easier for clients and continuity of care. We believe this will increase the number of participants in programs.

3. Southern Iowa Trolley is located in Creston. It provides transportation services in multiple communities including towns in Adair, Adams and Taylor Counties. With Union County in Region 5, residents in these counties with transportation issues would have to wait for the traveling WIC clinic to return to their respective county, as no transportation service is available to communities in the other counties in Region 3. Union County needs to be included in Region 3 in order to lessen this barrier.

4. I would like to comment on the new proposed collaborative service areas. We have been pleased with [agency] serving our area for the WIC programs over the past several years in [county] county. Our area was served by another agency in the past and had several complaints by a lot of families. The families were not treated well and did not get what they thought out of the services. [Agency] has did a great job of

providing adequate services to our area. From the proposed map, [county] county would not be in our area where [agency] is located. I would like to see [agency] to continue to serve the families in [county] county and other surrounding counties.

5. The Project Period for WIC is listed as October 1, 2017 through September 30, 2023. You can probably do it because you are the state, but just because you can doesn't mean you should and sets a precedent that providing false information and essentially lying is acceptable so should be expected in our collaborative areas. Please provide an explanation as to why, especially now during a pandemic? Agency strategic plans and community engagements have been created with timelines, based on these dates; professional staff have been hired, based on these dates.

6. A. How does the state draw a positive correlation between decreasing the number of contracted agencies in a service area, with improved health outcomes for program participants?

   B. Will the RFP for FFY2023 be a single RFP encompassing Maternal, Child and Adolescent Health services, I-Smile service, and 1st five services? Currently there are two separate RFPs (MCAH RFP and 1st Five RFP).

   C. One of the reasons for the proposed change by IDPH is "currently multiple WIC agencies serve a single MCAH agency and vice-versa." Wouldn't this still be the case if you have a single MCAH agency within a service area subcontracting with other MCAH agencies, and/or a single WIC agency subcontracting with others within the service area?

   D. Will an agency within a single service area be able to subcontract outside of their respective service area?

   E. Will the Maternal, Child and Adolescent Health funding opportunity for FY22 be an RFA or a competitive RFP?

   F. How will this proposed change affect the Tier 1 and Tier 2 Maternal health counties? For example, if an agency currently serves a Tier 1 county and is no longer providing direct maternal health billable services but is awarded the contract for FY23 for the service area, and the service area encompasses Tier 2 counties, would the agency be expected to provide billable services within the service area for the counties that are considered Tier 2 counties?

7. I am pleased to have the opportunity to provide my input regarding the formation of Collaborative Service Areas (CSA's). [county] County is currently served....I use the term "served" lightly...by [MCH Agency] for MCAH, I-Smile. and First Five. [WIC Agency]/[county] County provides WIC services for [County] County.

At our initial meeting with [County] County staff I assured them we looked forward to collaborating to provide services for our community. I was very clear that our past provider, [Agency], had provided excellent service and communication and it was our expectation that the level of service would not change with the switch in providers. Early on we began to experience lapse in service, spotty communication, and staff turnover. These issues predated COVID. The issues continued to the point that a mediation session was held at the state level.

I was hopeful that this regionalization would allow rural county agencies in southern Iowa to collaborate and share both their challenges and successes. As we reached out to other agencies in the region who were experiencing some of the same issues it seemed rather than sharing, agencies were isolated and siloed. At a meeting to resolve issues I asked if agency administrators might benefit from regular meetings to share and offer feedback...the response..." they already have too many meetings....." When I asked when will the agencies be allowed to evaluate the grant...." there is no evaluation tool in the grant..." . I find it interesting that as the state is now considering further regionalization I am asked for my input.

Further regionalization will only continue to remove the services and accountability for those services from the local public health agency and the folks they serve. Writing a grant is the easy part ... the real work begins once the grant is funded and implementing fully what you have put on paper.

Bigger is not always better. It is interesting that as we now address COVID on a county by county basis in Iowa .....at the same time a move to further group counties together to serve community public health needs is being considered.

I am available for further comment...

8. I appreciated that all four of our counties for our ECI area are in one proposed Collaborative Service Area. My concern comes in having different contractors that would be providing the difference services. Working in rural counties it would be much easier to have all services coming from one agency.

   I agree with one of the comments that was made that the agencies applying should be given adequate time to prepare and write the grant.

9. I am concerned that it seems Dallas County was put in the proposed service area to balance out the population of the proposed region without understanding the actual accessibility of the services provided. Currently, Dallas and Polk are served together as we share 4 cities that cross county borders, which comprises approximately 1/3 of the total population of Dallas County. If cities congruent to the metro are included it compromises over 57% of our total county population. We have many people who receive WIC services and live in Dallas County access them in Polk County during

their work day as currently they can attend any WIC location in the metro, which allows them to take a shorter period of time away from their jobs. This change in service areas will no longer allow people to access in-person services in Polk County.

The same issue could impact First V & MCH programs, many of our residents have a Primary Care Provider in Polk county as there are not that many clinics in Dallas County. Referrals made to those programs from Polk County PCP's would most likely be made to the Polk County awardee, who would then need to connect with the Dallas County awardee. This would result in delayed & possibly missed service connections.

Also, we just switched WIC providers the last time the RFP was released. The current program provider has done a lot of work to build relationships with clients that would be disrupted again. There are clients that will leave the program simply due to this inconsistency in service providers.

10. I have two questions about the your proposal for new Maternal Health related regions and consolidated services:

    A. Why is WIC not included along with the MCAH, I-Smile, and 1st Five?

    B. If the plan is currently to include all except WIC, why are there two separate application processes and timelines for MCAH/I-Smile and 1st Five?

11. I feel Union County should be made part of Region 3 for continuity of care. The hospital in Union County is a birthing hospital, serving Union/Adams/Adair/Ringgold/Taylor County, so by it not being with those other counties would mean referring out of service areas and the hospital having to juggle multiple agencies to work with when they feel their patients could benefit from WIC/MCAH services. Union County is also home to Southwest Iowa Trolley, which serves approximately the same service area. Same issue—if Union County is not moved to region 3, it will cause them to have work with both agencies if transportation is needed for appointments. Union County is also the base home/office for the Social Security Administration, SNAP program, Iowa Works, and SIRHA for those counties causing more of the same issues—if Union County is not moved to region 3, then both region 3 and region 5 will both need to be well-versed on Union County's available services and could cause confusion with both referring into them for participants, which I feel is the opposite of what the state is aiming for with this change.

12. While I appreciate IDPH wants to be improve things, the timing of the proposed CSAs is poor as we do not know the long term impact of Covid 19. Small business owners in smaller counties may lose their businesses due to poorly timed mandatory closures (Story and Johnson county bars recently). They may decide relocate to a more urban

area for more employment options; Likewise, the residents of larger populated counties may get fed up with hybrid learning that naturally accompanies larger schools due to the larger exposure pool and more positive tests. They may opt to move to a more rural area. Or the loss of a job in an affluent area may require lower housing costs offered by the more rural communities, necessitating a move. In other words, populations may change.

In addition, no one has been recovered from Covid for more than a year. We truly don't know the next steps of this pandemic. Like shingles and chicken pox (also viruses). We may see an entirely different set of symptoms requiring completely different public health measures.

Regardless, we are making long term decisions when we have the poorest indication of trends that we've had in decades! Please allow the Covid dust settle so we can actually determine the long term public health issues, population trends, economic impact. No one saw a pandemic at this time last year and we still do not know the impact and effect it will have on our families, counties, agencies, professional staff, state and nation. WIC, MCAH, 1st Five may not be the biggest priority in the coming months as we continue to navigate unchartered waters. Don't add one more struggle or burden to agencies that have been inundated with and responded to the constantly changing health environment. Mercy and Grace for these hard workers.

13. The effect Covid-19 already has on Iowans is degenerating.. add the derecho to the mix and you can't imagine much worse to happen to our state. Some will never fully recover from this. Now, IDPH wants to add this to their list?? We need years after 2020 to be growth for Iowan families and healthcare workers... not adding more to their plates.

14. Did IDPH really use all of their time during a GLOBAL PANDEMIC to attempt and screw all of the families and childcare providers in the state of Iowa with this "CSA" aka "BS". Smooth, IDPH. What's your next plan to screw our state???

(This comment was received from multiple individuals)

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16. We live in West Des Moines and have a home in Mt Ayr Iowa. The needs of the two areas are completely different. In West Des Moines we have multiple food pantries, Good Will stores and tons of supportive services.

    All services are limited in Mt Ayr. An agency serving both Dallas and Ringgold will automatically throw all their effort, time and support into the county with a bigger population, more people, larger voice!

    Dallas County would be able to provide more lead, vision and dental screens in an afternoon than they could in a month in Ringgold County and it will happen to get more money. Ringgold County will be an afterthought.

    Ringgold County needs to be included in Region 3 with counties that have similar demographics, where they are valued and not just another county to list.

    Thanks for listening to our concerns!

17. I would like to express concern about the proposed collaborative service area for WIC, MCH, 1st Five an I-Smile. Our counties are in the proposed service area 5. The rural counties would be better served by eliminating Dallas, Madison, Warren and Marion Counties from this service area. We know that when services are regionalized our smaller rural counties do not get the full services that are written in the grant contract. We often go without services as the larger counties that receive the contract do not have the staff or time to fulfill the need in our rural area. We feel our county would be better served by not being forced into a large service area such as you have proposed.

18. I am submitting a comment in regard to the Iowa Department of Public Health's decision to pre-determine the Collaborative Service Areas for WIC, MCAH, I-Smile,

and 1st Five clients. I am certain that IDPH feels that these service areas are best for the clients. However, I have a concern in regard to Areas 3 and 5.

I wish to comment on Collaborative Service Areas 3 and 5. Union County would be a part of Area 5. Area 5 has a much greater population that Area 3. In fact, Area 3 has shown a nearly 3% decrease and Area 5 has shown a nearly 26% increase in population since the 2010 census. Small counties have more barriers to overcome, especially those on the southern and eastern borders of Area 3. Since Union County is known for its many available services in southwest Iowa, it would better serve the southern and eastern counties of Area 3 if it were included in Area 3.

Secondly, there is a shortage of dietitians, nurses, dental hygienists, and dental assistants in Region 3. Union County has a surplus of these professionals. Including Union County in Area 3 would increase services to Area 3.

Thirdly, and lastly, I would like to comment on transportation issues. There is not a transportation service in the middle and western counties of Area 3. Union County is home to the Southern Iowa Trolley, which already serves Adams, Adair, and Taylor counties in Area 3. Including Union County in Area 3 would help to alleviate transportation issues in the aforementioned counties.

Thank you for allowing me to express my concerns. I genuinely care for these clients and I want only the best for them. They will always be near and dear to my heart.

19. IDPH has stated that the CSA is for a “collaborative approach” and that “strong partnerships”, “creativity and collaboration among community partners”, and “ensuring equitable services for clients” is the goal of this change. We of the 1st Five HMDI have years of experience, going back to the ABCDII project, in our counties of these exact outcomes. Respectfully, this specific type of 1st Five data was not collected/displayed in IDPH’s CSA region planning. 1st Five has a significant impact in areas of collaboration, partnership building, and ensuring equity of services for all clients.

    Major disruption of counties in previously aligned MCAH areas, will impact the trusting relationships that 1st Five has taken years to build with medical providers, referring community support services, and the families IDPH is trying to serve. For instance, we have a medical professional who provides pediatric services in two counties that currently are covered in our service area. Under the new change this provider will have to be informed and educated on which 1st Five Site they will need to refer to based upon which county clinic they are working. This is not in the interest of supporting relationships with medical providers or making referral supports for services for children/families straightforward for them to complete. This could have impacts on children being referred to 1st Five services for access to needed resources, due to this increased barrier for the medical provider.

1st Five has already built these strong and creatively collaborative partnerships with these needed services in order to ensure the equitable services for the WIC/MCAH population that IDPH is identifying is one of the reasons for this needed change. There will be significant impacts in the abilities, outcomes, and services for children and families if this current CSA comes thru as designed. Trusting, creative, and strong relationships take YEARS to put in place for effective and efficient services, exactly what IDPH has in place currently- and should want to continue to support in times of extreme stress for families.

The Issue: With the current COVID19 pandemic and the on-going uncertainty and likelihood of ACES such as: poverty, mental illness, domestic violence, child abuse/neglect, and other trauma rates increasing; one would think the IDPH would instead choose to focus on strengthening and building upon the existing architecture in Iowa, instead of dismantling and restructuring during an extreme time of distress and unknowns for families.

The Need: Children and families in Iowa need consistency and stability right now and the years upcoming, not more change and turmoil.

The Ask: Focus your efforts on strengthening current MCAH and WIC services areas.

20. In response to the proposed CSA for Dallas County:

- Potential number of clients to be served – I truly believe Dallas County residents will be best served by Polk County as systems are already in place to serve the population of both counties. We have been doing this for years; our data shows this.
- Physical area (distance) to be covered – A 10 county area from my own past experience is extremely difficult to establish and maintain especially when the diversity, economic makeup, and plentiful Polk County resources available in Dallas County is ever so different compared to the rest of the proposed region. Polk and Dallas County are just a few miles apart, hundreds commute between the two counties, the county line runs through apartment complexes/residential/businesses, and hundreds receive healthcare in Polk County. An agency that is several miles away is not invested nor have the communication lines it takes to keep systems seamless.
- Service delivery models between Polk and Dallas County run deep and have been in place for decades. Changing service models will gravely affect the vulnerable populations we serve. Changing to a foreign demographic area is dangerous and will very burdensome. It will be a taxing task and not favorable.
- Community partnerships- Coalitions, collaboratives, community needs assessments, and partnerships have worked together for seamless services. Removing stakeholders who are currently active in these relationship could be very detrimental.
- Ability to assure quality services and meet health needs of both rural and urban clients, relative to service area size- Eastern Dallas County is very

much like Polk County, county lines do not 'exist' in our current model. Dallas/Polk County is plentiful with resources and there is no one better to serve than your local community. We are proud of the progress that has been made and to disrupt that is not the right thing to do. We cannot base decisions on numbers; we are talking about people who have trusted us; it would break their hearts and the heart of providers who have worked so hard to create equity, empathy, and are genuinely care for their participants.

- I understand the goal to standardize and regionalization; putting Dallas County into an area that does not have the resources, manpower, or knowledge would not benefit anyone. Dallas County is not like the rest of the proposed are; they have a much different makeup. Putting Dallas County into the proposed area just to 'even out' the numbers is not the right thing to do – it is too much of a risk at the expense of the people. It will not add another region, just belong the right region with Polk County. I can assure you we have the manpower, resources, and systems already in place that can provide the upmost quality of care this population deserves. Why would we break something that is not broken? I am familiar with the 9 counties in CSA 5; they do not have the commitment or investment to provide services in Dallas County that are already in place – there will be a decrease of services and Dallas County deserves the best.

Please consider the above comments as you make the right decision. It will be very sad day if Dallas is not included with Polk County.

21. I was informed of the proposal to redraw the services areas and I have concerns about the financial and transportation strains this could impose on the recipients of these programs, families who are by definition financially struggling. Any restructuring of these program service areas must include accommodations so that poor and underserved recipients have adequate access to the supports these programs are intended to provide. This includes providing service days in communities and towns in or near all the rural areas and communities across the state, and financial compensation for travel if necessary.

    As a mental health professional serving rural southern Iowa I am advocating for these programs to remain as accessible as they currently are to best meet the needs of all the constituents receiving these benefits. These programs were developed to help children and families in need, not to hinder them.

    These proposed changes have not been widely publicized and are not known or understood by those involved with these programs, those who benefit from and literally rely on these programs. Its as if the IDPH is attempting to sneak these restructuring changes through with very limited opportunity for input and comment from stakeholders and constituents.

22. Under the new proposed service area we would be in Service Area 5. Currently we are served by [agency 1] for WIC from [county] county and the other services are

provided by [agency 2]. We would like to continue being served by [agency 1]. We have had a poor working relationship with [agency 2] in the past who is the lead agency under the current setup.

We would like to propose a group of 6 to 8 counties in the lower 2 tiers of counties ranging from Adams Taylor on the west to either Clarke/Decatur on the east for 6 county area or adding Lucas and Wayne counties on the east edge for a total of 8 counties. We are all smaller and we offer similar services and have worked well together in past.

In the past cycle [agency 2] has been very dominating and doesn't share well with smaller counties. Before the last realignment [county] County served as our lead agency and we were well served by them. Under the proposed area configuration our smaller counties will get lesser services. Our county board is hopeful you will revisit the proposed service areas. I you have question please contact me.

23. We need to keep MATURA in Region 3!! Transportation to and from dental services and medical services are definitely needed. We can't have more problems getting people to these places. The dental services provided to our school with the I SMILE program have been such a blessing. We are a small district and several of our families are unable to afford dental services. With I SMILE coming in and checking our students, they have provided a valuable service, that otherwise wouldn't be done. Please reconsider keeping MATURA in Region 3. We need to have services in our southwest Iowa. Thank you!

24. When examining to population trends in Region 3 and Region 5 over the past 10 years, the placement of Union County in Region 5 has the potential to create additional barriers for the other citizens in Region 3. With the current division, Region 5 has 83 cities and towns. Of these, 41 are listed in the 500 most highly populated cities and towns in Iowa or 8.2% of the entire state are in Region 5! In Region 3, 15.3% fewer communities exist, 72, with 34 listed in the top 500 populated cities and towns. 14 of the 34 are in Pottawattamie County or more than 41%. Higher population means more services from medical care, to gas stations, to childcare providers, to public transportation. The citizens in the smaller communities and towns, especially in the most southern and eastern portions of the Region 3 will lose even more support. They need a hub in the southwest portion of the state so Union County should be included in Region 3.

25. When examining the population trends in Region 3 and Region 5, Region 3's population has experienced nearly a 3% decrease from the 2010 census level (comparing official census numbers to estimated levels from 2019.) Contrast this with Region 5, which has experienced nearly a 26% **increase**. The needs, referrals and services are different for areas that are growing and thriving, compared to those that are barely maintaining. The barriers grow and grow for the small counties. It would serve the residents of the smaller counties, especially along the southern border, to

include Union County, already a hub for services in southwest Iowa, in Region 3. It also helps provides a better distribution of population and services.

26. Region 3 suffers a tremendous famine of dietitians, dental hygienists, dental assistants as well as nurses. Including Union County in Region 5, (Region 5 already has a larger pool to draw from for dietitians, dental hygienists, dental assistants and nurses), creates an even bigger drought in the rural areas of Region 3, limiting services to this vulnerable population. Some agencies have had to work with an exception to policy to fill 1st Five positions for years due to the lack of qualified applicants in the region.

27. City people never consider driving when coming up with these things. Some people from small towns and rural areas do not like to, feel comfortable, and frankly, shouldn't drive in the city. It's a skill set that requires ongoing practice. Sending people from small counties, like Decatur or Ringgold to Dallas County (staff too) is a huge problem for a lot of people and thus a huge barrier. Create a rural region that includes Page, Taylor, Ringgold, Decatur, Montgomery, Adams, Union and Clarke Counties.

28. I would like for you to please consider our recommendation of moving Union County to region 3 from region 5. The proposed Region 3 includes Adair, Adams, Cass, Fremont, Mills, Montgomery, Page, Pottawattamie and Taylor Counties. We already have strong collaborative relationships in place in these counties. "Including Union County in Region 3 still puts it on the edge of the service area but the relationship we have with providers, participants, partners and other professionals in Region 3 ensures easy collaboration, sharing of team members and creation of trustworthy subcontracts. Also, region 3 suffers a tremendous drought of dietitians, dental hygienists, dental assistants as well as nurses. Including Union County in Region 5, which has a surplus of all three, creates an even bigger drought in the rural areas of Region 3, limiting services to this vulnerable population. Some agencies have had to work with an exception to policy to fill 1st Five positions due to the lack of qualified applicants in the region as well as utilize their I-Smile Coordinators as direct service hygienist due to the lack available providers in the region 3 area.

    Thank you for your time and consideration in this matter that could greatly affect our Union county residents.

29. We as Taylor County Public Health Agency feel like the Collaborative Service Area (CSA) proposed by the Iowa Department of Public Health (IDPH) does not serve our population base in a manner that progresses the equity and access to care that they need. The proposal has great potential to further pull resources away from rural communities in Southern Iowa that we currently serve. We have built a foundation with these partnering organizations, communities, and families. Our agency and other smaller agencies have had success completing grant measurements and preform very well with recent metrics we've seen. Bigger collaborative service areas do not necessarily equal better performance and access to care for everyone. We

don't feel that balancing program and population data of service areas correlates to the most equitable MCAH services.

Furthermore, we feel like the collaborative service area plan does not align with many of the ten essential public health services that we need to provide to protect and promote the health of all people in all communities. Those include:

1. Building a diverse and skilled workforce. This has potential to take leadership, knowledge and valuable experience out of smaller communities and rural areas. There is potential for this to be disastrous and take jobs away from smaller communities, weakening the infrastructure and furthering discrepancy in social determinants of health between urban and rural.

2. Enabling Equitable access to care. Rural areas have potential to suffer and more populous areas will receive a disproportionate amount of resources. If one contract is granted per service area, many smaller agencies are at the mercy of having that contractor dictate distribution of resources. The new service structure has potential to weaken the power and engagement for rural areas and further create barriers to care.

We are proposing to breakdown service areas into smaller regions where relationships have already been established and the needs of the population served are more similar. Specific to our situation and the area we are most familiar with (SW Iowa), we propose a third region between service Area 3 and 5. A service region of 8 counties in Southern Iowa including Montgomery, Page, Adams, Taylor, Union, Ringgold, Clarke and Decatur would make more sense where needs are similar in each county and can be greater prioritized. Other agency administrators in these counites agree with the concerns noted above and have the same goal in mind. There is no need to create an artificial "hub" of services by grouping smaller counites with larger counties. We feel that having this service area would allow for an appropriate amount of local services for the needs in these communities. Our population in Southern Iowa needs support, Medicaid percentages in our region reflect this. Give us the opportunity to continue serving the population in our rural communities at the high standard we have been and continue to grow locally for the future.

30. The Taylor County Board of Supervisors would like to state our objection to the proposed WIC, MCAH, 1-Smile, 1st Five Collaborative Service Areas. This proposal would be detrimental to providing needed services in Taylor County.

    A realignment into a more rural region would, in our opinion, be a better solution. Our thoughts are a region consisting for Montgomery, Page, Adams, Taylor, Union, Clarke, Ringgold and Decatur Counties would better meet the needs of this area. This region would be able to better provide services in our rural areas due to proximity and a shared understanding of our rural needs.

    Please take our proposal into consideration.

31. Comments below reflect your intent of developing Family Health Programs. Since your proposal is to bundle together WIC, MCAH, I-Smile, and 1st Five there are programmatic changes that will need to be developed at the state level for this concept to truly address the needs of families.

    - Potential number of clients to be served
      When looking at potential, the data your provided for review would be the 0-5 Population est., Medicaid Enrolled (0-21), Medicaid Enrolled (0-5), Medicaid Births and Primary Care Providers. These are the ones that are not linked to Family Health program participation. When these numbers are compared, you see a large variance in total numbers related to potential clients There needs to be some adjustment that will better balance these, while taking into consideration the physical area that is covered. These two items are directly connected if improved services is your goal. When reviewing the proposed map, adding a region that just Woodbury and Ida counties were included, would distribute numbers more equitably in the northwest area of the state.

    - Physical area (distance) to be covered
      Physical distance for travel has a direct impact upon availability of services. In seven of your fourteen the distance span is over 100 miles from corner to corner of a proposed service territory. This will limit ability of contracted services to be provided. If this current structure is not modified, for availability of services will require major service delivery model overhauls and changes. It is interesting when you are proposing to expand service territories when the Iowa Primary Care Association has expanded and added many service points to meet the need of the population that is served through these programs. Their website indicates that they have 76 service centers located across the state.

    - Service delivery models
      If the intent is to improve access to services and expand service territories, the individual service delivery models can no longer be viewed from a program to program perspective. Telehealth has been an initiative that has been endorsed for serving rural populations and has been shown to be successful during the pandemic. Current service providers are only able to provide this now because of exceptions to contract that have been granted. What work can be done to continue and expand this flexibility across the state for all Family programs? This would not replace the face to face encounters, but supplement them and expand availability.

      Maternal Health has been sustained in a service delivery mode that is no longer seen as an asset by clients, unless you have a direct referral source from a medical provider as was documented in one of your webinars. Linking with a medical provider is an asset, but to develop this type of referral system when a service territory has up to 228 providers would be difficult to achieve.

1st Five – is there additional funding that will be available. New programs in this area have not been an option for about 6 years.

- Community partnerships
  Extensive community partnerships are essential for referrals. Each of these individual partnerships take time to develop trust. When you are spread across such a broad geographic region, this will be a challenge.

- Potential subcontracting
  This would be an approach that could be used, but with subcontracting there is a percentage of administrative overhead that needs to be covered. Reimbursement rates, grant funding reductions and many other factors limit how this can be accomplished Oversight and management is time consuming. If you lose a sub-contractor, you are expected to backfill those services which is not always possible.

  The contract management and compliance is a challenge in and of itself. Historically looking back, three of these four programs were assumed by my organization because of non-contract compliance by the previous contract holder. In one case we were asked to assume the services, in the other we were encouraged to assume them and then put into a competitive process with the previous contract holder. In all situations, it was due to non-compliance situations that were under the authority of IDPH.

- Ability to assure quality services and meet health needs of both rural and urban clients, relative to service area size.
  This is one that is difficult to comment on. With multiple data management and program input systems, collectively defining and documenting quality services and the ability to meet the health needs of both rural and urban counties is difficult. Needing to populate FOCUS, TAV and a combination of electronic MH that needs to be supplemented with paper documentation, it is difficult for any contracted agency to truly measure this. In addition to this, when looking from a Family Health perspective, there should be the capacity for information that is included within the four program areas to be shared with medical providers. If a family is facing multiple medical issues, and do have a primary care provider, it would be beneficial for the services they are receiving to be linked. For example, when a child receives a blood lead test during an appointment, if this is documented in one of the program databases, there should be the ability for this to be transferred to their medical provider and should not rely on a manual system. If you have a goal of increasing the number of children that are blood lead tested, then work should be done with the IDPH lead program, Family programs and connected with providers to assure this is occurring. This is a systemic change that needs to be driven from the state level, as opposed to each local contractor setting something like this up in each collaborative service area. There are also pertinent aspects of

nutrition education that is provided by WIC services that it would be appropriate to be communicated to providers.

- Other considerations
  As you review the many comments you receive, I ask that you take careful consideration in what you are proposing. The success of the changes will be determinant upon what ability there is at the state level to look at a family services model. It can no longer be based upon all of the independent factors of each program, but looked at from a collective fashion and service delivery mode.

  What linkages/coordination has been developed with the IPDH Lead program? If you are truly looking to meet the health needs of rural and urban residents, many factors must be taken into consideration, concessions between the programs must be made and looking at the systems that effect each program mapped and then reviewed to see where duplication is occurring.

  Expansion at this point of time, when there are program components that need to be more concisely and clearly linked will only lead to a difficult time of transition, in which I fear that fewer families will be served by the programs.

32. The Union County Board of Supervisors wishes to strongly protest the proposed reorganization of Iowa's collaborative service areas. Our contacts and alliances have been formed over many years. This plan splits our current region in half, essentially negating the proven, effective relationships built up over many decades.

    The new area 5 is predominately suburban and exurban, taking in a plethora of service providers, which mirrors its substantial growth In population since the last decennial census. In contrast, the new area 3 is largely rural and the relative paucity of doctors, nurses, dental hygienists, dieticians, etc. closely follows the slight decline in population it has experienced since 2010.

    We feel that Union County's residents will receive much better service by aligning with area 3, and earnestly urge you to take the required actions to bring this about. For many reasons, not all enunciated here, area 3 is more appropriate for Union County.

33. Calhoun County Public Health is currently in the Webster County MCAH, I-Smile, 1st Five Service Area and in the New Opportunities WIC Service area. The new Proposed Collaborative Service Area has Calhoun County in Service Area 2.

    The Calhoun County Board of Health passed a motion on September 28th, 2020 to submit a request that Calhoun County remain in Service Area 4 with Webster County for the following reasons:

    - The Calhoun County Board of Health is committed to supporting services provided by local providers. In the current service delivery model, Calhoun

County Public Health (CCPH) subcontracts with Webster County Dept of Health (WCDH) so that local public health department staff provide MCAH, I-Smile and 1st Five service.

- Stewart Memorial Community Hospital (SMCH) and providers in Calhoun County are aligned with the Unity Point Health-Fort Dodge Region Healthcare system. Aligning local public health with a regional health care system promotes a coordinated system of communication and service delivery. CCPH and SMCH have developed a Medical Home program where public health and hospital providers work together to serve families at well child visits. Keeping the CCPH MCAH, I-Smile and 1st Five programs in the same the health care region as SMCH promotes coordinated services to Calhoun County families and children.

- CCPH has developed several partnerships with SMCH to meet the needs of Calhoun County residents. For instance, hospital and public health staff have developed a SERT (Student Empowerment and Resilience Team) that meets monthly with school staff and providers to develop plans that address the needs of students in the South Central Calhoun School system. CCPH and SMCH staff also meet twice a month to provide care coordination services to adults who have health and social needs. As stated before, keeping CCPH in the same ACO Regional Health System as SMCH promotes a unified system of service delivery.

- WCHD contracts with CCPH for MCAH, I-Smile and 1st Five. CCPH to bills Medicaid through this system. These arrangements are vital revenue streams for CCPH and help assure the provision of public health services in Calhoun County.

- CCPH's relationship with WCHD is reciprocal. WCHD contracts with CCPH for regional services; CCPH contracts with WCHD for home visiting services. Referrals from MCAH, Unity Point-Fort Dodge and SMCH providers are a primary referral source to the home visitation program. Aligning WIC with this current system will strengthen services to families.

- Calhoun County, Pocahontas County and Webster County comprise the Linking Families and Communities Early Childhood Iowa area. CCPH, Pocahontas Home Care Aide Agency and WCHD have collaborated on a home visiting program for over 10 years. The three agencies are currently scheduled to have the home visitation program credentialled under the same set of program policies and procedures in December 2020. These policies include a vacancy policy where staff may be shared between agencies in times of staffing shortages. Families involved in home visitation are also typically involved in MCAH, I-Smile and 1st Five services. Keeping these three counties in the same service area creates a less complicated system of services for families to navigate.

- Calhoun, Pocahontas and Webster Counties are part of the same DECAT region which serves the same population as WIC, MCAH, I-Smile and 1st Five. CCPH Board of Health members also sit on the DECAT Board promoting communication and collaboration.

- Calhoun County is served by several social service agencies like Fort Dodge Housing, Dept. of Human Services, Community and Family Resources, etc. that have their main offices in Fort Dodge. 1st Five care coordination often involves referring families to these agencies. The MIDAS transportation system has a regular weekly route running between the Calhoun County cities of Rockwell City and Manson to Fort Dodge in Webster County.

- Calhoun is part of the Webster County Emergency Preparedness Region and has established partnerships, joint policies and procedures with hospitals, other public health agencies and emergency medical services is this region.

- Historically, Calhoun County residents have traveled to Fort Dodge for services available in an urban area. New Highway 20 has made this trip easier and shorter, making public health partnerships even more seamless.

- Manson Northwest Webster and Southeast Valley School Districts overlap Calhoun and Webster Counties. Both public health agencies have worked as partners to serve the two school districts. These partnerships have only strengthened during the COVID-19 pandemic. Both districts have held joint meetings with both public health departments. Nurses from both public health agencies and school nurses have worked to develop efficient systems to conduct contact tracing when cases overlap counties.

In closing, the Calhoun County Board of Health feels strongly that Calhoun County should remain in Service Area 4 with WCHD. CCPH and WCHD have worked diligently to develop collaborative, standardized systems of service delivery and have established a partnership in which services to children and families will continue to improve.

34. Below are some comments to take into consideration for the Dallas County proposal to move into Region 5. I am in agreement with the concept, however, I am not convinced the placement of Dallas County is in the best interest of families and community.
    - OB deliveries and OB care in Dallas/Polk are very connected and many Dallas County residents use Polk County healthcare providers. By having the same WIC agency serve both counties- continuity of care will continue.
    - Current staff live in Dallas County and know the county resources very well – they are invested in their community. I would think this would decrease administrative costs [travel, sub-contracting thus more for client services]
    - Dallas/Polk County lines bleed into each other which affects thousands of families for continuity of care for several programs.

- Partnerships between Dallas and Polk have been established for years: United Way of Central Iowa, Early Childhood, Central Iowa Community Health Needs Assessment, and Eat Greater Des Moines are just a few of the many coalitions/initiatives. My staff including myself are devoted to these partnerships – great strides have been made as we have common strategies in place to serve mutual families.
- Dallas County's demographic, population diversity, and the overall make up is very different compared to the other 9 counties [southern 3 tiers of Iowa]. Moving Dallas County into a far-off service area that do not have the knowledge/resources would be detrimental to families. Keeping Dallas County with Polk County will not increase service areas or affect funding levels for programs affected.
- The proposed CSA is very large and I am greatly concerned WIC services will not be provided in the format we are currently providing. We currently have clinics in 5 different towns and are present at least 8 days each month. Many Dallas County families go to River Plaza or West Des Moines. Under the proposal, WIC will only be required to provide services one day/month/county, a substantial decrease in services to those families.
- Dallas County WIC families have access to any clinic in Polk County – many are commuters and we provide accessibility 5 days/week. Our long term goal is to have a permanent site in Dallas County to further increase accessibility, co-locate services with other community partners, and provide a seamless service. This proposal will greatly disrupt services for families.

35. I have been reading about your redistribution for the WIC clinics and I would like to ask an important question. Why wasn't per capita income considered along with population? I am from Creston(Union County), and many of the people who live here would not be able to drive much farther to get these resources. Many don't even have cars. I think this would be a similar problem for the people in Lucas, Wayne, and Decanter Counties. I find it hard to understand that you linked up the 3 poorest counties with the two Wealthiest counties. At least the counties in Region 5 would be closer in distance and in community size. to base these models on population is misleading and unfair to the consumers. If you would like to explain this to me , I am willing to listen.

36. In regards to the planned reorganization of CSAs in the state of Iowa, I have several concerns and comments. As an elected official serving in a very rural county, I feel that the people I represent and care about greatly could be adversely affected by this change. My county is on the eastern edge of CSA 3 which already suffers from lack of service in healthcare, dental care, childcare etc. Proximity to these services can be critical to many people in these rural areas. There needs to be consideration as to how this population is served. If this plan is to move forward, I would be very much in favor of Union County being included in region 3 instead of region 5. Region 5 already has a large number of service providers. Union county providers serve a great number of people on the eastern edge of CSA 3 that would be very reluctant to, or have the ability to, travel.

I am also concerned that the possibility of change to WIC areas will result in people having to deal with different locations to obtain services from their Community Action Agencies. These agencies often serve as a “one stop shop” holistic model for information and help. Without additional knowledge as to what will be offered under this plan in regards to potential contracting out of services to other service agencies and how communities will be included in these partnerships, I think some changes or delays to your plan would be prudent. Thank you for your consideration.

37. I am writing to convey concern with the potential change in Collaborative Service Areas for WIC, MCAH, I-Smile and 1st Five programs. This will impact access to needed services for many individuals, especially children in our region.

    Greater Regional Health is a Regional delivery hospital in Southwest Iowa. Last year, our OB Department delivered 180 newborns. We are currently on track to do that this year. We have a new OB/Gyn Physician who just joined our other OB/Gyn Physician, along with 2 Family Practice and OB physicians and 1 Midwife - all delivering at Greater Regional Health. We draw OBs from surrounding counties to Union and beyond. Montgomery County Healthcare in Red Oak, Iowa, just closed their OB department in the hospital. Some of these women will go to Council Bluffs or Omaha, while some will come to Greater Regional Health. When a woman delivers, often post discharge support services are provided by the WIC clinic, which is located right in our town of Creston. The Mom and newborn often combine visits with their Primary Care/OB/Gyn Provider and WIC Clinic visit on the same day. If the 2 clinics are physically distanced, it is very likely that services will not be attained, as many of these individuals do not have access to transportation outside of going to one or the other. One of the largest draws between our OB and WIC is the Breastfeeding Peer Counselor provided by WIC, which is extremely beneficial to the mother and babe, as supported by evidence in breastfeeding a newborn.

    In looking at Medicaid rates, not just population rates, there is a large discrepancy in these areas. Dallas, Marion, Warren and Madison have a 28.7% Medicaid rate for 0-5 year-olds compared to the Southwest region, which has a 58% Medicaid rate. These individuals have the highest need for closer access to home, as well as needed proper nutritional supplies. Larger collaborative service areas do not necessarily equal better performance and access to care for everyone. We don't feel that balancing program and population data of service areas correlates to the most equitable MCAH services.

    IDPH has identified ten essential public health services-we must provide to protect and promote the health of all people in all communities. The following 2 essential services are at the highest risk of being negatively impacted:

    1. Building a diverse and skilled workforce. This has potential to take leadership, knowledge and valuable experience out of smaller communities and rural areas. There is potential for this to be disastrous and take jobs away from

smaller communities, weakening the infrastructure and furthering discrepancy in social determinants of health between urban and rural.

2. Enabling Equitable access to care. Rural areas have potential to suffer and more populous areas will receive a disproportionate amount of resources. If one contract is granted per service area, many smaller agencies are at the mercy of having that contractor dictate distribution of resources. The new service structure has potential to weaken the power and engagement for rural areas and further create barriers to care.

We are proposing to breakdown service areas into smaller regions where relationships have already been established and the needs of the population served are more similar. Specific to our situation and the area we are most familiar with (SW Iowa), we propose a third region between service Area 3 and 5.

Thank you for your attention in reviewing the concern for our patients and one of our most vulnerable populations, our youngest residents.

38. The Union County Board of Health discussed this new proposed service area map at its last meeting and is strongly against the proposed service area map.

    Currently the needs of Union County are being served though Matura Action Corporation with the service area including Adair, Adams, Taylor, Union, Ringgold, and Madison Counties. This is a wonderful partnership. This new proposed map rips the current partnership in half. There was no thought given to this longstanding and well servicing partnership when this map was drawn out. Half would go to region 3 (Adair, Adams, and Taylor) and half would go to region 5 (Madison, Ringgold, and Union). Matura would most likely write for region 3 as they would keep 2 MCAH counties. They also have a more sound relationships with the providers in Region 3. Without Union County being a part of Region 3, the Creston WIC clinics would most likely be handled as traveling clinics – here a couple of times a week only, without a permanent site. This creates barriers for anyone who delivers at the hospital – they have to be “lucky” to catch the WIC staff on a day they are in Creston and, Union County would no longer be served by MATURA for WIC, MCAH, BFPC and 1st Five. Union County Board of Health would be forced deal with a different agency that does not have the current working partnerships that Matura does.

    When examining the population trends in Region 3 and Region 5 over the past 10 years, the placement of Union County in Region 5 has the potential to create additional barriers for the other citizens in Region 3. With the current division, Region 5 has 83 cities and towns. Of these, 41 are listed in the 500 most highly populated cities and towns in Iowa or 8.2% of the entire state are in Region 5! In Region 3, 15.3% fewer communities exist, 72, with 34 listed in the top 500 populated cities and towns. 14 of the 34 are in Pottawattamie County or more than 41%. Higher population means more services from medical care, to gas stations, to childcare providers, to public transportation. The citizens in the smaller communities and towns,

especially in the most southern and eastern portions of the Region 3 will lose even more support. They need a hub in the southwest portion of the state so Union County should be included in Region 3.

We strongly encourage you to look at current well-functioning partnerships and revise your map.

39. I am writing in response to the Collaborative Service Area map for WIC, MCAH, I-Smile and 1st Five that I found on the IDPH website. I am requesting that Calhoun County be put into the CSA #4 with Webster and Pocahontas County. While there are many reasons for this, I will highlight just a few. Adding Calhoun County to that area:
    - Aligns with the Early Childhood Iowa Area (Calhoun, Pocahontas and Webster County).
    - Aligns with the Decategorization Area (Calhoun, Pocahontas and Webster County).
    - Would be familiar to Calhoun County families as Fort Dodge is the hub for family services and commerce.
    - Relationships have been built and are strong between Webster County Health Department and Calhoun County Public Health.
        - They are already collaborating to provide public health services.
        - They have a 10+ year collaborative relationship in a home visitation program.
        - They have been contracting with each other for various services for many, many years.

    In closing, I think that adding Calhoun County to CSA #4 is logical, as there are existing collaborations between the health departments and Calhoun County is proximal to Fort Dodge.

40. In consideration of the proposed collaborative service areas, our agency offers the following remarks. While our team can appreciate the rationale to better align MCAH and WIC service areas, we do not support the move to fewer, larger service areas as being in the best interest of clients. Time and time again, regionalization in other programs has shown otherwise. Furthermore, this comes at a time when many contractors are already pressed from dealing with the COVID-19 response, yet you are proposing agencies to be stretched even thinner.

    If your intent is to decrease competition, we believe this newly proposed service area will only result in pitting long-standing MCAH agencies against one another - and to an only slightly lesser extent, WIC agencies. Jobs are at stake in each of nine currently funded MCAH agencies and six WIC agencies. There are people behind those jobs - dedicated individuals who have tirelessly spent years in many cases learning the nuances of their service areas and building relationships with providers and community partners. Significant changes to service areas will disrupt many positive professional relationships and established rapport with clients in programs

such as I-Smile™ and 1st Five as well as MCAH and WIC. Again, relationships that have taken years to build.

In the case of 1st Five, providers will have to relearn where to refer clients and that's if they have time to reengage with the program under a new contract holder. The same is true with doctors and dentists who may refer to I-Smile™ Coordinators for care coordination or other assistance. The medical and dental communities are overburdened as it is and will likely not quickly or all too willingly adapt to this change. Then there are Child Care Nurse Consultants whose relationships with early childhood providers can take years to nurture. The fracture of relationships will only hurt Iowa's children and families.

Restructuring and rebuilding MCAH teams and the relationships and referral systems with providers and community partners they have worked so hard to build will take time. As suggested, possibly years. Certainly not overnight. Time to research and learn about new areas and populations. Time to approach brand new providers and community partners. Time to connect with new clients. Time to redirect former clients. Time to manage possible subcontracts. Time means grant money. Grant resources that could be better spent helping children and families at a time in Iowa when they need it most.

With the understanding a change to our service area is imminent, we ask you to instead consider involving the MCAH and WIC areas in further discussion for how to best look at their regions for potential changes, so that instead of increasing competition, you are allowing for continued collaboration and partnership in developing sound and appropriate CSA regions.

41. I am strongly encouraging the Iowa Department of Public Health to align county public health services including the Maternal and Child Health Program and WIC services with established regional hospital/health care systems. The importance of this alignment would strengthen our very rural Fort Dodge region in Webster County as well as our clinics in Wright, Humboldt, Pocahontas, Buena Vista, and Sac counties. The Managed Accountable Care Organization includes partnerships with the Humboldt County Memorial Hospital, Pocahontas Community Hospital, Buena Vista Regional Medical Center, Stewart Memorial Community Hospital, and Loring Hospital.

    Aligning a system focusing on integrating community based public health services and the Managed Accountable Care Organization will provide a more coordinated and collaborative delivery of holistic client centered services in northwest-central Iowa.

    The partnerships that we create and build on are invaluable to all organizations.

42. Webster County Health Department (WCHD) is requesting IDPH to consider including Calhoun and Sac Counties into Service Area 4 for reasons listed below.

43. Stewart Memorial Hospital in Calhoun County and Loring Hospital in Sac County align with the UnityPoint Health -Fort Dodge Region Healthcare System. UnityPoint Health-Fort Dodge Region Healthcare System affiliates with hospitals in the following counties: Webster, Sac, Pocahontas, Calhoun, Buena Vista, and Humboldt. Additionally UnityPoint Health-Fort Dodge Region and WCHD affiliate with UPH providers and local public health in Wright County and the hospital system and local public health in Hamilton County for Emergency Preparedness activities. This overarching eight county region provides coordinated services in northwest-central region of Iowa. WCHD is requesting that IDPH strongly consider aligning public health services with this established regional hospital/health care systems. WCHD would prioritize these eight counties in a regional approach to delivering holistic community care.

    This alignment has been successful during the regionalization of Emergency Preparedness activities. Aligning the delivery of MCAH services, 1 Five and WIC would provide a more streamlined approach to coordinating provider referrals and WIC/MCAH/1Five services. The established relationships with the UnityPoint Health -Fort Dodge Region focusing on communication and coordination between our hospitals, EMS, local providers and public health has strengthened other public health programming. Aligning WIC, MCAH, and ist Five in this holistic care would benefit the overall delivery of public health services in our communities.

    WCHD sub-contracts with the local public health agency in Calhoun County and Sac County to provide Medicaid eligible services. This sub-contract with Calhoun and Sac is a vital revenue stream to the local county budgets to support local services in the county and address the needs of children and families.

    Fort Dodge is a hub for rural counties. The new Highway 20 allows our populations to travel and cross county lines for multiple services including health care and public health services.

    Additional points to consider adding Calhoun County to Service Area 4 include:

    - Local public health in Calhoun, Webster and Pocahontas are working on credentialing jointly for the Iowa Family Support Credentialing Program, which aligns with our ECI area for Webster, Pocahontas and Calhoun.
    - Webster and Calhoun have 2 school districts that cross the county lines. Both public health departments coordinate, communicate and collaborate on MCAH, Immunization and other public health services to these schools.

    A note of concern from WCHD. Public health departments will be at a HUGE disadvantage with the governmental responsibilities of addressing COVID, planning mass vaccination clinics and coordinating mass vaccination plans. The additional time needed to write a competitive grant severely puts local public health at a disadvantage to submit the best applicant possible. All local public health offices are

operating at maximum capacity. The thought process and time to adequately plan and submit a grant of this significance and importance causes our department GREAT concern.

Please explain the rational and provide the supporting documentation that supports including Hardin County into Service Area 4 while removing Calhoun and Sac from an established structure.

Letters of support from the local board of the health and healthcare systems or providers in the established region would be beneficial to express the importance of aligning public health with healthcare networks. This is an important decision. It is more successful to implement programs with a healthcare system that supports local public health services.

WCHD appreciates the work of IDPH in moving forward with regionalizing and aligning service areas. Thank you for your time and consideration in this very important decision.

44. I very much appreciate the efforts you made in this plan. If I am understanding what you are planning, I especially appreciate the thought that we will no longer have to "start over" to create new systems of service every contract period based on new and different geographic areas. That is a huge bonus to providers, the community partners, and our residents in the communities we serve.

    I would ask that you reconsider the geographic areas, just a bit. This is an opportunity to launch into a more sustainable public health system in Iowa. In order to create a sustainable public health system, I believe the more standardized the geographic area across all program areas, the more there is to build on. This can help build synergistic relationships with and among public health agencies, enabling them to develop infrastructure, so they can hopefully serve their own citizens across all programs. I would request that you look one more time at the preparedness regions, and see if you can use those regions. This would put most of the "big rocks" together in the same jar, so to speak. Big rocks, gravel, sand, and water…..fills the jar most effectively.

    Thank you for your consideration and the courage to take this leap of faith to try new ways.

45. Is it possible for one contractor be awarded more than one service area?

46. This letter is in response to the Collaborative Service Area that you intend to implement in Iowa affecting the WIC, Maternal Health, I-Smile, and 1st Five programs throughout the State. We here at Upper Des Moines are very disappointed that input from the program providers was not solicited prior to you releasing this proposal. Further, it is very clear that input was solicited from select entities that have or will

benefit from your proposal if implemented. Whatever, evolves from this, I am certain that partnerships between providers and client trust will be irreparably damaged due to this approach.

As a provider ofWIC services for several decades, we would like to offer the following as a justification to NOT implement the changes that you are proposing.

- UDMO, Inc. service area is split roughly down the middle making it impractical to apply for the grants. We can try for one area to compete with your peers or try for the other area to compete with an entity who's only interest is funding; nothing more.
- The grant was not to be competitive until 2023 however it is stated in the contract that the IDPH can change the rules. Why?
- This will be a major disruption in services for many of our clients. We have individuals that travel across service areas due to our staff friendliness and appointment availability.
- We have great collaboration with our partners seen in the Referrals into our program and out from our program such as OB depts., medical clinics, local Public Health, DHS, Outreaches, Cherish House, Head Start, A.EA, & KIDS.
- We do referral to Webster county for their Maternal and Child Health services (usually 1st time mothers that consent for it and for any I-Smiles dental concerns)
- Breastfeeding Prevalence and Duration has increased since 10/1/2019 with the personal breast pump incentive.
- Participant numbers have increased with the new service delivery during the COVID.
- Current numbers as of 8/31/20; Unduplicated (10/19- 8/20) 2665; Current participants: 2036.
- We have received commendation from your office for exceeding our participation numbers when other providers were exceedingly low.

Our biggest concern with all of this is damage and/or challenges placed on our clients. With COVID-19, disasters and economic challenges being faced by our clients, this only adds to the problems they face every day. The proposition that this would put all of the programs under one roof doesn't hold water. Not every client needs all of the programming and if they did it would take several hours in one's day to be able to get through an average review/exam. Thank you for taking the time to read about our concerns and we do hope that you all reconsider your position.

47. 1. Has IDPH considered that while local agencies are dealing with the current COVID-19 pandemic and the disruption in services, that this may not be the best time to implement major contract changes? Is it possible to delay these changes for at least one year? This would also allow for better communication between IDPH staff

and local agencies on how the current regions were chosen and to collaborate on other options that may be a better fit in the various regions.

2. On the “Why is IDPH making changes now?” slide, reasons include: currently multiple WIC agencies serve a single MCAH agency and vice-versa and inconsistencies leading to service issues for program participants. While having the same service region may improve these issues, there is still potential for these inconsistencies to continue if different contractors receive the funding for the individual programs. How does combining service areas guarantee quality? It is still necessary for agencies to make a concerted effort in order to collaborate. Unfortunately, it can take years to re-build these collaborative relationships that become strained when contracts are competitive. These processes cause agencies to compete rather than collaborate and in the long run limit the number of potential service providers in any one region. In addition, competitive grants are most often awarded based on scoring. This process does not guarantee quality.

3. 1st Five funds have not been available to additional MCAH contractors for many years. Has IDPH considered incorporating these funds into the MCAH contract to eliminate the need for an additional RFP and to allow all contractors to receive 1st Five funds?

4. While we can understand the addition of counties to our current five-county service delivery area, we have concerns with the proposed regions.

- Our proposed region includes 10 counties with over 100 miles from corner to corner. With larger regions to cover, it becomes difficult to build collaborative relationships in counties where they are not familiar with your agency, your services or your staff. The amount of time that would need to be spent building collaborations in additional counties will be extensive.
- In addition, the physical distance for travel will have a direct impact on the availability of services. When traveling to WIC/MCAH clinics, staff will have a 1 ½ hour travel time (one way) in addition to a ½ hour of clinic set-up and tear down. With current grant requirements to provide “after-hour” services, these late-night clinics will make it difficult to hire new staff and even more difficult to maintain current staff.
- We understand subcontracting will be an option. However, the contract management, oversight, and compliance issues with subcontracting, often causes more administrative overhead. Out of 50 contracts that our agency manages, the MCAH programs/funding is one of the most complex. Has the state considered that requiring current agencies to take on more counties, may actually cause agencies to discontinue their MCAH contracts? While creating bigger service regions may simplify the administration of grants at the state level, it will cause additional administrative costs at the local level. This in

turn, decreases local agency funds that could be better spent on client services and program activities.

5. There are current contractors who have both the MCAH and the WIC contracts due to these contracts being issued as one many years ago. We have an existing 5 county service area where all of the available services are within our agency. Why is it necessary to change regions that have accomplished the goals expressed in this new process?

6. Proposed region 1 includes Woodbury County which is primarily urban (Sioux City) with 9 rural counties. would be considered rural which requires a much different delivery method and numerous arrangements for clinic sites, interpretation services, etc. The total 0-5 population in region 1 is listed as 19,844. This is the 3rd largest of the proposed regions. The smallest in terms of 0-5 population has 8,561 in region 2. Adding another region which could include Woodbury and Ida counties would make more sense in terms of driving distances and 0-5 population. This would bring region 1 (0-5) population to 10,501 and the new region would have 9,343. This is still larger than 3 of the other proposed service regions. Many of the collaborative arrangements currently in place could remain and transition would be much easier. Bigger is not always better especially when target populations live in very rural areas with limited services. Allowing for an additional region would keep most, if not all, collaborations in place and provide for a smoother transition.

7. Telehealth options have proven to be very effective for Maternal Health services during the COVID-19 Pandemic. With the larger service areas and the amount of travel time that would be required, is IDPH working to continue and expand this flexibility across the state for MCAH programs?

48. Sac County Health is requesting IDPH to consider including Sac County into Service Area 4 for reasons listed below.

Loring Hospital in Sac County aligns with the UnityPoint Health -Fort Dodge Region Healthcare System. Unity Point Health-Fort Dodge Region Healthcare System affiliates with hospitals in the following counties: Webster, Sac, Pocahontas, Calhoun, Buena Vista, and Humboldt. Additionally UnityPoint Health-Fort Dodge Region affiliates with UPH providers in Wright County and the hospital system in Hamilton County for Emergency Preparedness activities. This overarching eight county region provides coordinated services in northwest-central region of Iowa. WCHD is requesting that IDPH strongly consider aligning public health services with this established regional hospital/health care systems.

This alignment has been successful during the alignment of Emergency Preparedness activities. Aligning the delivery of MCAH services, 1 Five and WIC would provide a more streamlined approach to coordinating provider referrals and

WIC/MCAH/IFive services. There has been established relationships with the Unity Point Health -Fort Dodge Region focusing on communication and coordination between our hospitals, EMS, local providers and public health has strengthened other public health programming. Aligning WIC, MCAH, and 1st Five in this holistic care would benefit the overall delivery of public health services in our communities.

Sac County Health has a sub-contract with Webster County Health Department to provide Medicaid eligible services. This sub-contract for Sac is a vital revenue stream to the local county budgets to support local services in the county and address the needs of children and families.

Fort Dodge is a hub for rural counties. The new Highway 20 allows our populations to travel and cross county lines for multiple services including health care and public health services.

Additional points to consider adding Sac County to Service Area 4:

- Our public health departments within the current service area currently coordinate, communicate and collaborate on MCAH, Immunization and other public health services with schools, family support programs, and disease outbreaks etc. This has been a great partnership and works well for our communities.

Public health departments will be at a HUGE disadvantage with the governmental responsibilities of addressing COVID, planning mass vaccination clinics and coordinating mass vaccination plans. Adding the additional time needed to write a competitive grant severely puts local public health at a disadvantage to submit the best applicant possible. All local public health offices are operating at maximum capacity. The thought process and time to adequately plan and submit a grant of this significance and importance causes our department GREAT concern.

I would like the supporting documentation and the rationale that includes removing Sac from the current established structure.

Prior communication and discussions with local boards of health, health care systems and local public health systems would have been instrumental in aligning regions for the delivery of public health services. This is an important decision.

What will be different moving forward to assure WIC and MCAH agencies work in a collaborative manner?

Letters of support from the local board of the health and healthcare systems or providers in the established region would be beneficial to express the importance of

aligning public health with healthcare networks. It is more successful to implement programs with a healthcare system that supports local public health services.

Sac County Health appreciates the work of IDPH in moving forward with regionalizing and aligning service areas.

49. I would like to make comment on the intended collaborative service area. I hope that they will consider moving Union County into Region 3 and that it would make since because we are a rural area and Union County has been the main hub in the area for many years. It has taken a lot of man power and collaboration to develop partnerships and referral resources. Many agencies with in the area would be affected with the potential change.

    Union County is also the main area for shopping and transportation. Our local stores would be affected and could lead to loss of more businesses closing.

    WIC clinics would decrease in number of clinics, which would also affect other direct services. This would also cause a decrease in staffing with in our region.

    Thank you for the opportunity to provide feedback and the opportunity to be a voice for our area.

50. Thank you for the opportunity to provide feedback on the Proposed Collaborative Service Areas. I applaud the department for looking for ways to improve services to individuals and families, and look for ways to increase collaboration. I am certain that a lot of hard work went into identifying the potential service areas.

    We have been a WIC provider for decades, and have worked hard to establish collaborative relationships with the other IDPH funded programs. We include other providers in our clinics, locate a WIC clinic in a Maternal Health clinic, etc. I am not sure that changing geographical boundaries for programs will result in the improved services that you are hoping for, however, as it doesn't fundamentally change the services being provided unless the requirements are changed. Another concern is that some of the areas might not have enough "critical mass" to support the provision of some of the smaller, less well funded services; I know that some providers have struggled for years trying to make the program funding stretch cover the cost of the services. Maybe with the significant reduction of contracts that IDPH would have to manage, some additional funds will be freed up for local service provision.

    While one of the goals was to even out the size of the service areas, Area 11 seems to be almost twice the size of the other multi-county clusters. So, it seems like the clusters around Area 11 could be reconfigured.

    Thank you again for the opportunity to provide input.

51. Thank you for the opportunity to provide feedback regarding the MCAH Collaborative Service Areas. I have some concerns about these proposed changes, the primary one being I do not see how this benefits the people accessing the services. The CAP agency currently serving my county has been doing this work with us for years and has well-established relationships with a wide variety of community service partners. They participate in our community meetings. They can make referrals to other programs in our communities and ensure their clients are getting all the services and help they need. How would having a new agency, potentially located further away, be able to provide the same level of service?

    And while these new CSAs might simplify grant administration at the state, it could make administration of the program much more complicated locally with the (likely) necessary subcontracts. I believe some of the other feedback you have already received addresses other concerns, such as your choice of regions and the timeline for implementing these changes.

    Unlike previous experiences with IDPH and new service areas, I hope you do actually consider the feedback you are receiving rather than simply asking for feedback and ignoring anything that doesn't agree with your plan.

52. Thank you for sharing the proposed Collaborative Service Area with the public for comment prior to finalizing the plans. I can see how the development of the Collaborative Service Areas could have benefits for counties with small numbers or to reduce the need for clients to go back and forth between entities for services when RFPs are variably awarded to different entities over time. I do not really see the data telling the story about where and how these problems are currently affecting communities in the information provided. I think that information is vital to the development of effective CSAs.

    As a medical provider trying to optimize care for patients, I am concerned about the disruption of services through this process. I think the losing and gaining entities will do their best to provide continuity of care and transition amongst themselves. The aspect that I am worried about is mainly focused on the awareness that providers will have regarding what is offered in a community and how best to refer patients to the entities that can help meet their needs. After being in the area for 3 years, I find that I am still learning about programs in our community that can benefit our patients. I think there is often a gap in provider knowledge about various programs and any changes in the location/management/services provided within programs should be minimized as much as possible.

    In consideration of resources for patients within the community, my county is currently within the 10% of counties that does not have 1st Five. I heard the comment within the presentation regarding funding required to implement 1st Five in the districts that do not currently have this program. I hope that working to secure the funding

necessary for this expansion is a major priority for IDPH as we embark upon this project. It has been really disappointing our area has been left behind without a clear plan to develop the program within our county.

Finally, with respect to the implementation of these CSAs, I am concerned about the ability to provide the same quality/quantity of services when it is spread out over a larger area, the combination of rural and urban settings within the CSAs and the contrasting boundaries with other programming like ECI and MH/DS. This is where the data to show where redundancies or lack of full resource utilization would be helpful to ascertain the best boundaries for the CSAs. It would seem best to develop boundaries consistent with other programs to the greatest extent possible and to consider grouping rural areas together and urban areas together. Perhaps this would result in somewhat smaller regions that make the provision of services easier while having less administrative burden (managing subcontracts) and appropriate consolidation of resources. Ultimately, the more consistent the regions are with the regions of other programs and the more consistent they are with current entities, the easier to get patients in touch with the services that they need.