Audubon County Public Health Nursing Service

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Jeanne Schwab, RN, B.S.N
Agency Administrator

August 8, 2016

Rebecca Curtis
Bureau Chief-Emergency and Trauma Services
Iowa Department of Public Health
321 E. 12th St
Des Moines, IA 50319

Dear Ms. Curtis,

The Audubon County Board of Health met today and reviewed the proposed Time Critical Conditions Service Area alignment map and talking points. The Board members expressed concerns over the size of the service area with which Audubon County is aligned. Audubon County would be one of 24 counties in the service area, which includes the largest metropolitan area of the state. The members also expressed concern regarding the rural/urban mix. Twenty four counties is one fourth of the number of counties in the state.

Thank you the opportunity to comment on the service areas.

Sincerely,

Jeanne Schwab

Jeanne Schwab, RN, BSN
Nurse Administrator

JASPER COUNTY HEALTH DEPARTMENT
115 N 2ND AVE E, NEWTON, IA 50208
(641) 787-9224

5/27/2016

To: Ken Sharp and Rebecca Curtiss,

RE: New proposal for structure in FY18

I attended the BETS Partnership Development Workshop on 5/26/2016 in Ankeny. I am the Administrator for Jasper County Health Department. I want to start by saying that I am in support of regional coalitions, even though Jasper County is not currently involved with other counties. Jasper County Health Department has been in conversation with Poweshiek, Marshall, and Tama Counties and a separate conversation with Marion County for future multi-county coalition opportunities.

I am writing to voice my concern about the regions, I believe that all the hubs will most likely be the large metropolitan areas such as Polk County in my case. This will greatly limit access to funding in the rural counties which will probably be lost due to grouping with these large metro areas.

Public health agencies and smaller hospitals will end up doing the "work" such as policies, trainings, grant checklist, drills, inventory, partnerships, etc, while the coalition funding will mostly be used in the larger metro areas. There will be very little incentive for rural public health and hospitals to participate in the massive amount of grant requirements for little or no funding for the time and energy put in at the local level.

Please consider the negative funding impact on rural counties.

Sincerely,

Becky Pryor

Becky Pryor, Administrator
Jasper County Health Department
bpryor@co.jasper.ia.us

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RMC
Regional Medical Center
Administrative Agency

TO: Iowa Department of Public Health

FROM: Delaware County Public Health

DATE: Tuesday, August 16th, 2016

RE: Proposed Geographical Map for Emergency Preparedness Coalitions

Delaware County Public Health (DCPH) response to the proposed PHEP geographical map:

- DCPH would not have the personnel and/or resources to act as fiscal agent for the proposed size of our coalition.
- It is concerning this territory proposed has so many partners (counties) that Delaware County has no working history with i.e. LPHSC, EMA Regions, and past preparedness regions. In the past, these regions primarily mimicked each other. That is not to suggest that we can't work together, rather stating the fact this will be starting from scratch when historical relationships have already been formed. We would propose to reevaluate geographical areas and make regions smaller when working with new partners.
- DCPH has acted as the fiscal agent for the EMS grant for the past 2 years. Relationships have begun, but to address the EMS concerns is separate than coalition planning. It is our contention that the EMS problems should be addressed separate from the preparedness coalitions and will need funds specific to them and oversite by local partners vs regional partners.
- EMS does not normally plan with outside counties. They work exclusively within their service areas to optimize the quality of their work.
- Through discussing the map with EMS, their opinion would be IDPH has never supported them in the past. They question what would make them want to work with IDPH now. The view from EMS is that all monies will be used for bigger counties. Especially if the funds are designated to one regional pot.

DCPH believes it is **imperative** to set up a system that assures there are funds to support emergency preparedness directly to our county. In the absence of direct funding, DCPH would need to evaluate if able to commit to the FY18 grant cycle.

At the most recent ICPHA meeting on August 11th, 2016 concerns discussed regarding the new regional preparedness map included:

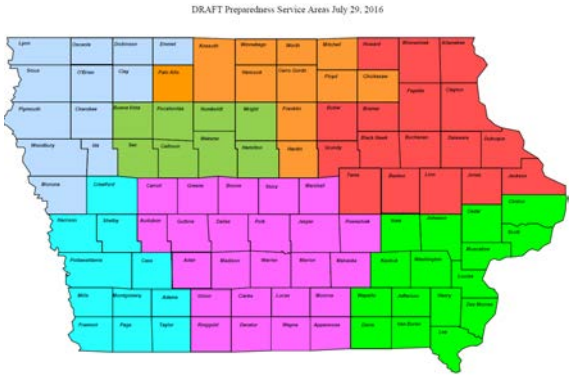
- IDPH has developed a geographical map that does not coincide with other service area maps already in place. (EPI, CHSC, EMA, Regional Emergency Preparedness Maps from before).
- There was also concern about public health funds being re-directed towards EMS and how this would impact the ability for any or all of the systems to respond.

DCPH proposes making our preparedness coalition smaller, by decreasing the number of new counties and/ or returning to the previous Region 6, including those counties with established multi county coalitions. Much of Region 6 has continued to meet on a monthly basis during the current grant cycle.

Sincerely,
Delma Hardin, BSN, RN
Delaware County Public Health Manager

Linn County Public Health Feedback
IDPH TIME CRITICAL CONDITIONS SERVICE AREAS-FY 18 AND BEYOND

Contacts:	Pramod Dwivedi Pramod.dwivedi@linncounty.org Julie Stephens julie.stephens@linncounty.org



Background: Linn County Public Health (LCPH) served as the Region 6 Fiscal Agent (FA) in the previous regional structure. Region 6 was comprised of 14 health departments and 22 hospitals. The FA was employed by LCPH and in the form of one FTE. In the early years of Region 6 PHEP planners were LCPH employees; however other counties and hospitals later contracted with LCPH to hire the planners. Some planners were subcontracted and others were employees of another Region 6 public health agency or hospital.

Local funds were identified for the hospitals and public health agencies. A second group of "regional" funds was provided for regional staff and regional projects.

The request for feedback noted "map only." A single reference of the region being too large would not include supporting information for the size comment.

Positive Contributors

- IDPH provided regional presentation of information in May and June 2016.
- Contacts are established for many EMA, EMS, public health and hospitals in the northeast region.

Potential Barriers

- The region is too large if you plan to merge funding sources. They should be smaller if funding is in one contract. If IDPH provides base funding for local health departments/hospitals and another portion of money is "regional" to cover projects, a larger region may work.

- Due to region size a significant burden would be placed on the local public health agency serving as the fiscal agency. Burdens include but are not limited to:
  - Currently we do not have to subcontract with coalition members for supplies and time. Subcontracting with all EMS, hospital, and public health agencies impacts time on legal, auditing and local public health agency staff. It is recognized there should be accountability. Contracting with a large group to include many we don't currently work with will have local agency impact.
  - Reliance on others to submit information/deliverables - This can impact other agency funding. Much time is spent in small coalitions gathering comments and metric approval. This would be magnified if coalition is expanded from one or two counties to 17 counties.
  - We have been told the planner would be an employee of the health department. Due to coalition size the local public health agency would need to purchase a car for use or pay mileage. Each comes with a financial impact to the local agency. Most agencies reimburse mileage at a rate higher than can be billed to the PHEP and HPP grants. There is also the issue of unemployment, bumping consequences, and turnover (if they know the position is temporary).
  - Specific funding has been identified for the planner position; however FA funding has not been established.
  - NIMS Compliance maintenance of multiple entities – This is much more labor intensive in the "coalition" structure vs previous fiscal entity. It is our understanding the IDPH requirement of FA tracking exceeds that of EMA tracking for response entities (to include public health) for a given county. This time consuming activity will be intensified if you add multiple agencies (including many EMS agencies) to the coalition. NOTE: LCPH supports NIMS training and NIMS compliancy. It is vital in community response. Tracking responsibility of FA is the issue.
  - Dollar amount would require additional external auditing. Auditing alone not the issue. This is a potential increased expense for the county.
  - The funding/spending guidelines for three portions of funding in one contract will need to be managed.
  - Coordination of the planning needed for the FY18 RFP would occur in FY17. Who is the lead? Would it be the FA or a governing body of the coalition? Some feel it would be the responsibility of the FA, when in fact the FA is responsible for the submission, but the effort should come from the coalition.

- Some local health agencies have restrictions linking to the addition of new positions. This timeline may conflict with the grant thus delay hiring.
- It is understood IDPH works with some counties/hospitals/EMS agencies who struggle to spend PHEP/HPP/EMS funding. Perhaps working with those counties would better strengthen response. Many other hospitals/public health agencies/EMS have a solid process for planning and community support projects. Altering "what works" is counter-productive.

- Travel to meetings could be a barrier for some response agencies with large coalition.
- Lack of local funding is difficult in the local budget planning for most county health departments.
- Some EMS organizations are new to the HPP/PHEP process. Some EMS organizations have worked through boards of health; others prefer to work with boards of supervisors.
- In the end, if IDPH determines they must have large regions, they should be aligned with EMA response regions. The exception in Region 6 would be if Black Hawk would like to maintain the coalition they have had for the past few years.

Additional Considerations

- Without local funding, concurrence may be impacted.
- Counties/hospitals who have worked to strengthen local, regional, and state response will now be in competition for preparedness dollars.
- There are currently EMS regional planners/coordinators employed by IDPH. Could these planners/coordinators be utilized for IDPH efforts linked to EMS preparedness efforts?
- Potential politics with money division if base/population is not used to determine funding to local levels
- Determination of "voting" for coalition activities. It is recognized IDPH is trying to move away from PHEP/HPP/EMS "pots" of money, but the PHEP, HPP, and EMS funds come with specific guidelines and related measures.
- HPP and PHEP dollars in the regional grant are preparedness. It is my understanding the EMS dollars are not preparedness related. They are system development dollars. Components of preparedness and system development align; however the differences should be addressed. Different deliverables could be an added strain (but potentially manageable) on coalition.

Rebecca Curtiss
Bureau Chief-Emergency and Trauma Services
ADPER & EH
Iowa Department of Public Health
321 E.12th Street
Des Moines, Iowa 50319

August 16, 2016

Rebecca,

Thank you for the opportunity to provide member feedback regarding the proposed service areas sent out by IDPH last month.

We ask for reconsideration of the service area we are penciled in, as it actually cuts in half the geographical service area we are actively involved within. We have the greatest opportunity to strengthen collaborative relationships and foster interoperable system development when those areas mentioned below are included.

As you stated, "When time critical events occur, patients who need care migrate to appropriately capable facilities which provide a framework for local partners to work together as a system to ensure the most appropriate and effective level of care for the population. " We believe we have the most opportunities and need to work on this framework with those who come in contact with us most frequently.

We have reviewed data using MSDRG diagnosis codes from IHA (reviewing for acute cardiac, stroke, and trauma) to see the service area we are in. We looked at 2014 (as you noted IDPH did for its proposed service area designation) but we also expanded to 2011-2015 (and the first part of 2016) to look for a wider data reference set for recent historical trending, anomalies, and general comparison. A summary of the data is attached.

Beyond the historical data, there are more recent developments that impact the scope and quality of system building and support commitment. Your 2014 data does not reflect strong new growth in cardiac care capacity with the addition of two interventional cardiologists and contracted commitment to Mission Lifeline initiatives. The data selected by IDPH precedes our growing collaborative care partnership with Marshalltown's community hospital and the systems, vulnerabilities and capabilities that extend to its service areas.

Also occurring after the IDPH data collection period, consider that we are nearing the completion of a 130 million-dollar expansion and renovation that includes doubling service areas for Emergency Services and ambulance garage/reception and support areas. Additionally, we remain the only inpatient behavioral health unit between Sioux City and Waterloo and Mason City and Des Moines (and have two new rooms specially designed for BH crisis patients in our Emergency department). While not listed as a time-sensitive medical emergency, this attests to our commitment to regional system clinical/resource support

The data, summarized in the attachment identifies historical patient 'migration patterns' that include the following counties for the previously identified time sensitive emergencies (cardiac, stroke, and trauma)—Story, Boone, Marshall, Hardin, Hamilton, and Greene. Additional noteworthy numbers are from Tama and Carroll counties, especially when coupled with the strong hospital within Carroll County and our partner facility, Marshalltown's Central Iowa Healthcare. Webster and Wright counties show significant numbers. Though not shown in the data summary, numbers from Dallas, Marion, and Grundy, as well as from northern Polk, also attest to the reputation and strength of patient allegiance and a growing service area.

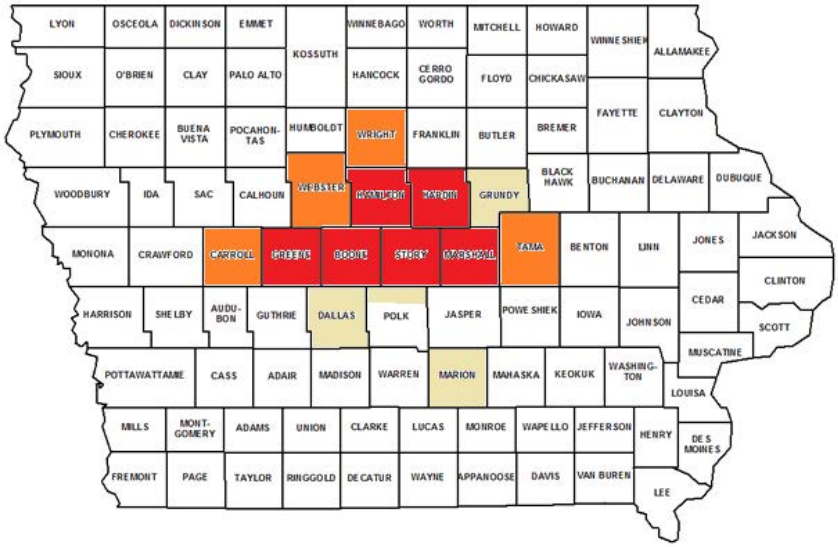
The number one source of out-of-county ambulance tiers for time sensitive emergencies for MGMC comes the county immediately north of us, Hamilton. We have existing system improvement activities with them.

For the vey reasons cited in your communication explaining the Service areas;

> "As many communities within a geographic area will have similar vulnerabilities as well as patient care patterns, it is important to establish responsibilities and capacities in advance of disasters to be able to work toward common goals when an entire area is impacted."

And including the data and evidence cited previously, we ask that you reconsider the service area that includes Story County so that it includes, at a minimum the counties/areas previously listed in this communication, en masse---**Story**, **Boone**, **Greene**, **Carroll**, **Marshall**, **Hamilton**, **Hardin**, **Wright**, **Webster** and **Tama**, at a minimum. Consider Grundy, Dallas, and Marion counties. The sole exception to consideration, if service areas are to keep counties intact, would be northern Polk County, as strong systems support exists within it already.

We look forward to working with you to explore, define and provide the best possible solutions For the present and future health care of our constituents.



Scott County Healthcare Coalition Feedback
IDPH TIME CRITICAL CONDITIONS SERVICE AREAS-FY 18 AND BEYOND

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The Scott County Healthcare Coalition is providing feedback on the proposed FY 18 coalition service area mapping that was proposed by IDPH. The request for feedback stated that comments should be specific to the "map only", however, providing a reference that the service area/region is too large would not allow supporting information justifying the comment to be made.

Recommendations

- Jackson County should be relocated to the South Eastern region/service area with Scott and Clinton Counties to consolidate Genesis affiliated facilities, i.e., Genesis VNA and the Jackson County Regional Medical Center.
- If IDPH determines that the coalition service areas/regions must be shifted to a larger format, they should align themselves to the EMA response regions. The exception in Region 6 would be if Black Hawk wanted to maintain the coalition they have had for the past few years.

Potential Barriers

- The Region is too large if the current plan is to merge funding sources; the region should be smaller if the funding is part of one contract. If IDPH created a specific pool of funding for hospitals and local health departments and a second pool of money for regional planning, a larger region could work.
    - One Pool of funding may also create a first come first served system in terms of planning dollars. Agencies within the coalition could tailor their planning efforts to secure dollars early, rather than waiting at the risk of running out of funds.
- Some health departments have limitations on when they can create new positions; this timeline may conflict with the grant schedule, delaying the hiring for key positions.

- Due to region size a significant burden would be placed on the local public health department serving as the fiscal agency. Burdens include but are not limited to:
    - Reliance on others to submit deliverables – This can potentially impact other agencies and their funding. A great deal of time is spent gathering comments and metric approval in small counties, this time will be magnified if the coalition sizes are increased to 17 counties.
    - The planner position is required to be an employee of the health department. Due to the size of the new coalitions, the local health department would have to purchase a vehicle for use or pay mileage. Each comes with a financial responsibility for the local public health agency. Most agencies reimburse mileage at a higher rate than the grant allows. There is also the issue of unemployment, bumping consequences, and turnover (if they know the position is temporary).
    - Specific funding has been identified for the planner, but no such funding has been identified for the FA.
- Travel to meetings could be an issue for some response agencies with large coalitions, specifically agencies staffed by volunteer first responders. These individuals may have full time day jobs which would not allow them to attend any meeting during regular working hours.

Potential Considerations

- Counties/Hospitals who have worked to strengthen local, regional, and state response will now be in competition for preparedness dollars.
- There has been no discussion of whether supporting a planner and/or fiscal agent takes away from the overall planning dollars or whether the funding for these positions will be a separate pool in the grant funds.
- There has been no discussion of how the Federal (PHEP/HPP) and the State (EMS systems development grant) dollars will be separated or if these dollars will be pooled together. Currently Federal and State funds have different guidelines; if the pools of funding are combined, specific criteria would need to be given detailing how these funds can be used.
- There needs to be an opt-out policy discussing how an agency opting out will affect the other members of the county and the other members of the coalition.

August 15, 2016

Rebecca,

Last week, we took the time to discuss the proposal for FY18 emergency preparedness at both our Tri-State Disaster meeting and our Woodbury coalition meeting. Tri-State Disaster includes representatives from many aspects of community preparedness and includes people from South Dakota and Nebraska organizations. Our coalition meeting, of course, includes the two hospitals in Sioux City, Siouxland District Health, and both our emergency manager and emergency medical services director.

Our initial comment is that our service area seems too big. Logistically, it's a challenge to get even the public health people together for meetings from such a large geographical area. But now adding EMS, etc to create an even larger group… with such significant travel to attend the necessary meetings… it will be very difficult to create any type of cohesive group.

But more important than the size of the area, is the fact that the northern counties simply don't belong to the same system as the counties to the south part of the region. The table below shows data from the Iowa Hospital Association. This simple table is the number of INPATIENTS with ER charges at UnityPoint-St. Luke's Sioux City and Mercy Medical Center-Sioux City for 2015.

COUNTY	POPULATION	INPATIENTS WITH ER CHARGES A EITHER MERCY OR UNITY POINT (TOTAL)	RATE PER 1000 POPULATION
LYON	11,745	4	0.34
OSCEOLA	6,154	1	0.16
DICKINSON	17,111	5	0.29
EMMET	9,769	0	0
PALO ALTO	9,133	1	0.11
CLAY	16,507	25	1.51
O'BRIEN	13,984	103	7.35
SIOUX	34,937	161	4.61
PLYMOUTH	24,800	605	24.4
CHEROKEE	11,574	132	11.4
BUENA VISTA	20,493	194	9.5
POCAHONTAS	7,008	7	1.0
SAC	10,021	69	6.9
IDA	7,028	149	21.3
WOODBURY	102,782	5698	55.4
MONONA	8,979	187	20.8
CRAWFORD	17,094	38	2.2
CAROLL	20,498	5	0.24

This chart clearly shows from which counties people are coming to the two largest hospitals in the region. We thought that INPATIENTS WITH ER CHARGES was a decent measure even though the focus of the current proposal is focused on time critical conditions. If they were inpatients, it means that they were sick enough to need a hospital stay. It also shows where relationships between the medical systems exist. It's logical to assume those same relationships will hold true for time critical conditions.

Ambulance data received from UnityPoint-St.Luke's Sioux City show similar results. They get a lot more ambulances from Buena Vista County than the northern counties.

Obviously, there are many other factors to discuss when considering what makes up a healthcare system. But this quick data shows that the northern counties being considered in our service area really aren't part of the same system as the others. Sioux Falls is a much bigger factor in the northern area.

Our tentative recommendation for a service area would be: Woodbury, Monona, Crawford, Sac, Ida, Plymouth, Cherokee, and Buena Vista. The above data does show that O'Brien and Sioux counties could be included within this service area too, but that would leave the northern service area quite small.

A couple notes… I am just submitting a summary of what we discussed at our recent meetings. Our partners have reviewed these comments, but they are also free to give their comments to you directly as they may have a few other opinions of their own. Also… by submitting these comments, Siouxland District Health is not committing to serving as the fiscal agent for this FY18 proposal. We're not ruling out the possibility of being the fiscal, but we do have serious reservations about taking it on.

Thanks for considering our comments.

Sincerely,

Tyler Brock
Siouxland District Health Department

University Hospital Advisory Committee

Emergency Management Subcommittee

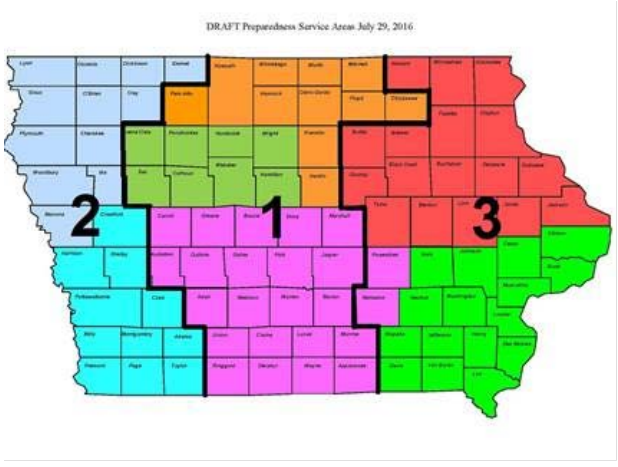
August 16, 2016

To: Rebecca Curtis, Bureau Chief, Iowa Department of Public Health

Re: Proposed Service Area Map for Aligning Preparedness, EMS and Time Critical Conditions

The 34 members of our Emergency Management Subcommittee at the University of Iowa Hospitals and Clinics represent a variety of areas and expertise, including preparedness, trauma care, Emergency Medical Services, Cardiovascular and Stroke care, and Pediatrics. Last week we carefully considered the proposed IDPH "Service Area" re-alignment map and discussed the merits and capabilities of the seven proposed areas. We voted to summarize the most prominent points of our discussion and write you this letter in response to your request for comments about the map of seven "Proposed Service Areas".

We respectfully recommend that you consider dividing the state into three "Service Areas" rather than seven. Below is a possible resulting map. These large "Service Areas" would then divide themselves into multiple, individually-governed "response districts" to assure that local-level response command and control is maintained.



The Subcommittee members agree with you that the existing structure of 70+ healthcare coalitions in Iowa is neither efficient nor effective in achieving the intended preparedness initiatives as outlined in the *National Guidance for Healthcare System Preparedness*. We believe that our recommendation to reduce the number of

"Service Areas" from seven to three will simplify the implementation of your bold and ambitious program and increase the likelihood of its eventual success. The win-win situation created by this approach would enable the state to reduce its regional fiscal/planning infrastructure to a manageable number, while allowing the locals to determine the size and make-up of the local structures needed to assure efficient response.

Some members reflected that the initial federal concept was to form approximately 100 coalitions nationally, with Iowa forming around two, considering our population, its geographic distribution and the location of Iowa's major healthcare resources. However, in scrutinizing the major referral patterns for trauma, stroke, and STEMI, we saw clearly three – not two – major areas of referral: The Des Moines-Ames-Mason City corridor mid-state, the Iowa City-Cedar Rapids-Quad Cities-Waterloo-Dubuque corridor on the east, and the Sioux City and Council Bluffs areas on the west that often refer out of state to Nebraska and South Dakota. Recent discussions concerning the alignment of highly infectious disease case management with this proposed structure further confirms the logic of the three "Service Areas" approach.

We appreciate the effort of examining relatively recent patterns of patient referral and EMS transport for time-critical conditions and using these data to guide the re-alignment of the existing coalitions. However, these data do not represent well the variation in local response (rural, suburban, and urban) during routine day-to-day emergency operations. The initial response to daily emergencies, mass casualty incidents and patients with time-critical conditions remains first and foremost a local concern. After further discussion, we considered accommodating these local response systems by designating them as local "response districts" within the three larger "Service Areas".

We acknowledge that you requested comments only about the map at this time. However, since the map determines implementation, we also discussed practicalities of its fiscal management. The fiscal challenges associated with coordinating and maintaining both local and regional systems of response and care can be daunting and beyond the capacity of most local entities. Hence, we believe that starting with a simple and logically structured map that is based upon the location of Iowa's major healthcare resources will ultimately secure a more efficient statewide structure in the future.

By establishing one "Fiscal Agent" in each of three large "Service Areas", IDPH would deal with a simplified application process that involves more homogenous geographic divisions (the west being the smallest). It would then be up to each "Service Area" to disperse the funding and provide regionalized planning support, (with perhaps three FTE's each or more), to the locals that have been organized into smaller, self-determined sub-divisions. At a later time, we can share our thoughts on these smaller subdivisions, or "response districts", as we feel this will be a critical feature of Iowa's future structure.

We hope that you have found our recommendations and related comments useful. Please contact us with any questions, especially if we can be of further help.

Respectfully submitted on behalf of the Subcommittee,

[s] Signature on file

Jonathan Simmons, D.O., M.Sc., F.C.C.P.
Chair, Emergency Management Subcommittee

[s] Signature on file

Carlyn Christensen-Szalanski, M.D., F.A.A.P.
Vice Chair, Emergency Management Subcommittee

Winneshiek County
PUBLIC HEALTH
Caring for the Community

305 Montgomery Street, Suite #3
Decorah, IA 52101

August 16, 2016

Dear Ms. Curtiss,

I am writing to express my concerns about the proposed Service Areas for FY 18 and Beyond.

I can understand the rationale for some of the areas but, am quite disturbed by others. The area in orange (north central Iowa) is all a part of the Mercy system and they do quite a lot together already. I believe the lighter green area is served by Fort Dodge.

I am concerned about continuity for those of us in the red area in northeast Iowa. This proposed service area simply does not make sense. If you are looking at cases of highly infectious disease, cardiac events, stroke, and trauma, patients in Allamakee and Winneshiek counties will go to Rochester, MN or LaCrosse, WI. These time-critical conditions are being met by these providers. These are mega-systems already in place with specialty clinics co-located in primary clinics in each of the counties. They just do not go to Iowa City or Waterloo for care. It's considered too far and they can get the services they need at a pretty local level.

I find it hard to believe that the entire red region has similar vulnerabilities. The northern two tiers of counties in the red region are more rural while the southern tier is more industrial and urban. The regions are much too large as well. We all realize that face-to-face meetings are much more productive but, in this world of needing to get way too much done with not enough time and resources, it appears that there will be too much windshield time with regions this size. Partners will refuse to send staff to meetings because they simply cannot afford for them to out of the office. The rural communities have it together. They know how to work together because they've had to. A few noses may have been put out of place over situations but, in the end, it was all about the residents.

I believe this is being rushed. It's wrong to try to build a comprehensive system by slapping some counties together and telling them to work together to meet these goals. It's the wrong approach and you will be sadly disappointed when nothing good comes from it and the state ends up taking 3 steps backwards. This will take time, perhaps by having a couple of counties work together and then then adding to them in a couple of years.

I am trying to keep an open mind to this but, in reviewing the notes, I have trouble believing this would work in Iowa as proposed. I suggest going back to the drawing board, literally, and reviewing affiliations and associations that already exist. Take a look at the similarities and differences. Match like with like—you'll have a stronger group in the end. As proposed, you're strengthening the metro areas and disabling the rural areas. Thank you.

Sincerely,

Krista M. Vanden Brink, RN, BA

Krista M. Vanden Brink, RN, BA
Administrator

Phone: 563.382.4662 www.winneshiekhealth.org Fax: 563.387.4121

August 15, 2016

Dear Rebecca,

The Wright County Coalition is respectfully requesting a change in the proposed service area alignment for the HPP PHEP grant. Wright County's demographics consist of three similar in population towns of Eagle Grove, Clarion and Belmond with several smaller communities of Goldfield, Woolstock, Dows, Rowan and Galt. There are two hospitals in Wright County; Iowa Specialty Hospital in Clarion and Iowa Specialty Hospital in Belmond.

The destination patterns of patients being transferred from either Iowa Specialty Hospital campus as calculated in Fiscal Year 2016 are as follows. Out of 584 responses in FY2016, 23.46% or 137 responses went to Mercy Medical Center – North Iowa whereas 4.28% or 25 responses went to Trinity Regional Hospital in Ft. Dodge. Furthermore, the city of Eagle Grove transports to Iowa Specialty Hospital in Clarion 169 times or 61% and to Fort Dodge 88 times or 32% of the trips documented in Fiscal year 2016. While we appreciate the work and data used to align the service areas, we feel our preparedness needs would be better met going to North and Eastern Counties including Hancock, Franklin and Cerro-Gordo, and aligning with Mercy in Mason City.

Wright County currently has an EMS advisory committee working on developing EMS solutions and developing stronger EMS partnerships for all the communities in Wright County. One of the goals will be looking at response times for critical illnesses for our smaller communities including Dows. Dows sits on the Wright and Franklin County line and has been serviced by both Clarion and Hampton ambulance services. This is just an example of how our needs naturally draw us to the East.

Wright County EMA has developed and maintained cooperative efforts and meets regularly with the 18 counties in the Iowa HSEMD District/Region 2. The working relationships within this District were demonstrated in Wright County this spring during a table top and full scale exercise that included Kossuth, Humboldt, Butler and Floyd counties. In addition Wright County EMA provided assistance for a full scale exercise in Cerro Gordo County in May.

Thank you for your time and your careful consideration of this request.

Respectfully,

Kathy Nicholls
Administrator
Wright County Health Department

Jim Lester
EMA
Wright County Emergency Management

Amy McDaniel
CEO
Iowa Specialty Hospital Belmond

Steve Simonin
CEO
Iowa Specialty Hospital Clarion

Sandy McGrath
Environmental Health
Wright County Health Department

Tom Butler
Safety and Disaster Preparedness Coordinator
Iowa Specialty Hospitals Belmond and Clarion