Iowa Department of Public Health - Bureau of Oral & Health Delivery Systems

THE ACCESS Update

JUNE 2012

In this issue...

Over 5,500 students have enrolled and over 2,500 have completed IT programs across the 10-state region.

Health Information Technology: A Workforce Challenge with Some Solutions

Gloria Vermie RN, MPH, Iowa Office of Rural Health

As health care evolves to deliver more effective communication systems, one huge challenge is the expansion of the information technology (IT) workforce. This challenge is magnified in rural and frontier areas of the nation.

To help meet the growing demand for health information technology (HIT) professionals, the Office of the National Coordinator for Health Information Technology funded the Workforce Development Program. The goal was to train a new workforce of skilled health IT professionals to help providers implement electronic health records and achieve meaningful use. One of the four initiatives implemented is the Community College Consortia. There are 82 community colleges in all 50 states. The goal is to:

- Offer intensive, non-degree training programs that can be completed in six months or less
- Address the growing demand for highly skilled health IT specialists
- Train more than 10,500 new health IT professionals annually by 2012

According to Norma Morganti, executive director, of the Midwest Community College Health Information Technology Consortium, over 5,500 students have enrolled and over 2,500 have completed programs across the 10-state region.

Iowa Works on HIT Solutions

In Iowa, two of the programs are located at Des Moines Area Community College (DMACC) and Kirkwood Community College.

Jane Herrmann, program lead at DMACC, reports the certificate courses are 100 percent online which allows for maximum participation and access to the course.

"We have worked closely with the Iowa Health Information Technology Regional Extension Center and utilized some of their key staff in the instructional process and in getting the word to the rural health care workers about the grant funded training. Recently we had an information booth at the Iowa Health Information Management Association conference and recruited several new students."

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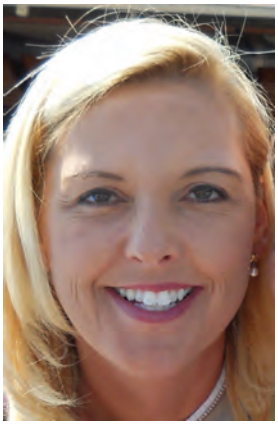
Robbin Rekemeyer, HIT project coordinator at Kirkwood Community College, shared that the average Kirkwood HIT grant program student is in their late 40's with over 15 years of experience in the health care or IT fields. Graduates must have excellent time management skills in order to complete the comprehensive course work in six months as required while working and meeting family obligations.

Success Story from Tammy Philby at Montgomery County Memorial Hospital



Tammy Philby of Montgomery County

My background as a medical technologist and as the lab director left me with an intense desire to improve patient safety and satisfaction, while finding more effective ways for my coworkers to do their difficult jobs. The promises of information technology are great, but the imperative is that it be done correctly, and it is a lot of work! I needed more technical knowledge to help me do my job better.

Our hospital CEO knew exactly what I was looking for and steered me to the Kirkwood Community College HIT program. The program was everything I hoped for. I was concerned about the time limit since I had a 40+ hour a week job and a young daughter at home, but I did it by dedicating an average of 1 to 2 hours a day. The course studies helped to bridge the gap between myself and the technical IT people and gave a great understanding of electronic health record meaningful use, workflow analysis and redesign, and professionalism.

Today, I'm a full time clinical analyst and have branched out to more clinical applications including physician office EMR, scheduling, and interfaces between many of the hospital applications. I feel that heath care workers are beginning to realize the benefits of having good data that at their fingertips to help them do their jobs better. Also, gathering good clinical data will help us improve patient safety and support advances in health care.

2011 Public Health Supervision Results

Heather Miller, RDH, CPM, Oral Health Consultant

The need for dental care in Iowa is great. Dental caries is the single most common chronic disease of childhood, yet it is largely preventable. As a way to increase access to dental care, lower costs, and promote better health outcomes for Iowa families, the Iowa Dental Board has rules that allow the public health supervision of dental hygienists. This type of supervision allows oral health services to be provided in designated public health settings without the direct supervision of a dentist.

Public health supervision agreements are becoming more accepted in Iowa with the belief that preventive care can best be accomplished through a patient centered, collaborative team approach that benefits both the individuals served and the health care system. The services provided by dental hygienists, such as fluoride varnish and sealants, can do much to alleviate the barriers families have to receiving care.

Each year, the Iowa Department of Public Health, Oral Health Center, compiles the total number of services provided by hygienists under public health supervision. The 2011 report is now on the OHC website: http://www.idph.state.ia.us/hpcdp/common/pdf/oral_health/2011_ph_services.pdf.

In calendar year 2011, 76 dental hygienists provided over 160,500 preventive services (the majority to children under the age of 21). In addition, over 38,300 clients were referred to dentists for further follow-up care and/or treatment. Compared to 2010, the number of providers in addition to the number of services has significantly increased.

2012 State Children's Champion Award

As noted in the last edition of *The Access Update*, OHDS Bureau Chief and State Public Health Dental Director Dr. Bob Russell was nominated by the Iowa Head Start program to receive a 2012 State Children's Champion Award. Dr. Russell attended the Region VII Head Start Association's Leadership Conference and Award Ceremony on May 24, 2012, and accepted his award on behalf of the I-Smile™ program.

In addition to Dr. Russell, three other State Children's Champions were named. U.S. Representative Kevin Yoder from Kansas; George A. Lombardi, director of the Department of Corrections in Missouri; and Dr. Dawn Mollenkopf of Nebraska all received recognition by the Region VII Head Start Association.

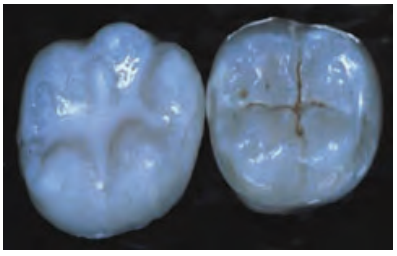
Other Iowa awards included:

- Beating the Odds Parent Award – Rob Seigwarth
- Head Start Alumni, High School Senior Award – Luria Staats
- Head Start Staff Higher Education Award – Kathy Hall

The Access Update congratulates Dr. Russell and all awardees for this great honor!

Structural Cavities in Rural Dental Health

Chuck Shuford, *The Daily Yonder*



Many cavities can be prevented with dental sealants (shown on tooth, far left). A few states already offer sealant programs in schools.

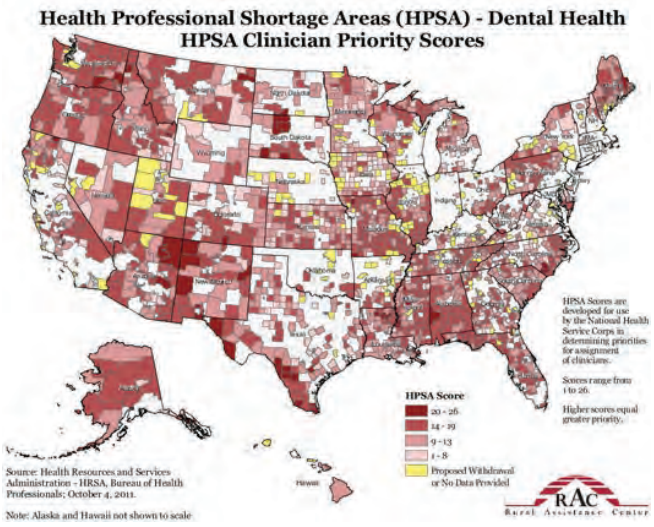
In 2000, the federal government issued the first-ever Surgeon General's report on Oral Health, emphasizing disparities across the nation. It warned that dental disease in the U.S. constituted a "silent epidemic" with profound consequences for "affected populations."

In rural America, the "silent" epidemic is in fact strident. In February of this year, The Pew Center for the States issued new evidence that poor dental health is especially severe among rural children and adults. The Pew Center's Dental Health Campaign reports:

- Total tooth loss among seniors increases as the population becomes more rural.
- Rural residents are more likely to have lost all of their teeth as compared to their non-rural counterparts.
- Rural adults are significantly more likely than non-rural adults to have untreated dental decay (32.6 percent compared to 25.7 percent).
- In 2001, 67.1 percent of urban residents had visited the dentist in the past year as compared to 58.3 percent in rural areas.
- The likelihood that a child will be insured for dental work declines steadily as the county of residence becomes more rural

The outpouring of patients availing themselves of the Remote Area Medical Volunteer Corps (RAM) , which provides free medical and dental care, offers an unvarnished view of the dental needs in rural America. In October 2011, RAM visited Grundy, Virginia in rural southwest Virginia. By 5 a.m., hundreds stood in the freezing rain to see a dentist. By the end of the weekend 900 teeth had been pulled. In 2012, 17 such clinics are already planned by RAM, with similar numbers expected.

Why the discrepancies between rural and the rest of the nation? The national media has tended to focus on emotional and superficial commentary related to soft drink consumption, and to an extent the images they project and the stories they tell are embedded in tragic fact. But the whole nation is hooked on syrupy, caffeine-laced empty calories. Although not always as visible, there are structural issues at work that explain a lot.



Rural Assistance Center: This map prepared by the Health Resources and Services Administration shows where the the highest priorities are for placing dental professionals. The darker the county, the greater the need for more dentists and hygienists.

Access to Dental Care

There is a severe shortage of dentists in many rural areas. The U.S. Department of Health and Human Services reports that at the end of 2011 there were 4,670 dental Health Professional Shortage Areas in the U.S. Sixty-five percent of those were in non-metropolitan areas. Without strong incentives to bring dentists to rural communities, this situation may only get worse. Nationally, rural areas had a higher percentage of general dentists age 56 or older than did urban areas (42% vs. 38%). In remote locations, 44 percent of dentists are age 56 or older.

Affordability

The number of dental graduates has declined over the last 30 years while the nation's population has expanded by about one-third. When supply decreases or demand increases, prices rise. When both happen at the same time, prices rise abruptly.

In many areas it's difficult to find dentists willing to treat Medicaid patients. Because of low reimbursement rates, paperwork burdens and the perception of a higher percentage of missed appointments, only 1 in 5 dentists

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Structural Cavities in Rural Dental Health continued from page 4

accepts Medicaid or State Children's Health Insurance Program (SCHIP) patients; many such patients are rural residents. In 2008 a Congressional Subcommittee reported that 37 percent of children in Medicaid ages 2 through 18 received dental care. These rates are far below the Department of Health and Human Services' target for low-income children's preventive dental care: 66 percent.

Dental Insurance

Rural children are less likely than urban children to be covered by dental insurance, and children who lack dental insurance are markedly less likely to have made an annual dental visit. Additionally, insurance reimbursement rates—both public and private—for dental procedures are typically lower in rural areas even though the costs of providing services are often higher in rural areas.

Fluoridation

The CDC has identified community water fluoridation as one of the 10 great public health achievements of the 20th Century and a major contributor to the dramatic decline in tooth decay. The American Dental Association (ADA) reports that every dollar spent on fluoridation saves $38 in dental procedures.

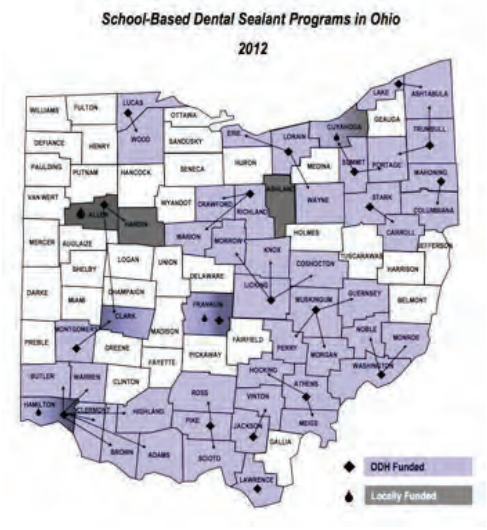
Rural residents are less likely than urban dwellers to have access to fluoridated water. Sixty-seven percent of the nation's population is currently served by fluoridated water systems, but fewer small town water systems are fluoridated. Perhaps this is because water fluoridation is six times more costly per person in communities with fewer than 5,000 people than for water systems serving more than 20,000, according to the CDC. And, of course, few of the forty million Americans who get their drinking water from private wells drink fluoridated water.

New Directions

The good news is that these problems are fixable. The bad news is we're not likely to see significant progress on these issues anytime soon. Despite the Surgeon General's trumpeting the "silent epidemic" a dozen years ago, the nation's dental maladies remain relatively unnoticed, perhaps because they represent less than 5 percent of health care spending, while the more expensive health problems command attention. Should policymakers find the political will to move forward on these issues, though, there is already widespread agreement among government agencies, associations of health professionals, foundations, and NGO's on solutions.

The most fundamentally effective and least expensive step—no federal policy required—is early intervention. The ADA recommends tooth brushing as soon as a child has its first tooth. No toothpaste is needed until age two. As important as cleaning teeth is feeding teeth. Children should eat more fruits and vegetables and avoid sugary drinks.

Many worthy policy ideas are being articulated to improve dental health and access to care. Here are four approaches that appear with regularity and stand out for their potential.



Ohio Department of Health: Ohio's dental sealant program, in operation since the mid-1980s, serves low-income schools in most of the state.

School-based or school-linked sealant programs: Sealants cost one-third of what a filling costs, and they don't have to be applied by dentists. Since poor children suffer twice as much untreated tooth decay as their more prosperous peers, sealant programs targeted to schools with high risk children have proven cost-effective. Despite evidence that these programs can produce intended results and are relatively inexpensive, Pew found that only 17 states have sealant programs that reach even one-quarter of their high-risk schools; 11 states reported having no programs at all. Ohio's sealant program has been praised by the CDC. Because poor children have little access to dental care, some pediatricians are also learning how to apply fluoride varnish on baby teeth, a simple procedure that can prevent cavities.

Fluoridation: As of 2009, there were 25 states providing less than 75 percent of their population (the national goal) with fluoridated water. Water fluoridation laws are set at state and local levels, and only 12 states and the District of Columbia have mandatory fluoridation laws. In areas lacking mandates, technical and financial assistance are advisable to small towns to help fluoridate water systems.

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Structural Cavities in Rural Dental Health continued from page 5

Increase government payments for dentistry: States are currently required to provide all medically needed dental services for Medicaid-enrolled children and emergency dental services only for adults. Dental services are not covered under Medicare. With only 1 in 4 dentists nationally accepting Medicaid enrolled patients, the poor and elderly are at huge disadvantages. Low-income adults and seniors would be well-served if Medicare covered dental services and if Medicaid provided preventive dentistry and included transportation as an ancillary service. It is widely recognized that raising reimbursement rates and reducing administrative procedures for dentists who, in general, have higher overhead costs than other medical providers, will be necessary to convince more dentists to accept Medicaid patients. When Tennessee and Alabama raised reimbursement and altered administrative procedures in the late 1990s and early 2000s, the number of children receiving dental services doubled in just 4 years.

Innovative workforce models: A growing number of states are exploring ways to expand the types of skilled professionals who can provide high-quality dental health care to children. Washington state and North Carolina have pioneered projects that set the standard for training and paying physicians, nurses, and medical staff to provide preventive care to very young children. Thirty-five states now reimburse for these services through Medicaid. Dental hygienists are the primary providers in school-based sealant programs in most states, but state laws vary in how they govern this work and many state laws need to be changed.

One of the most innovative developments—and most controversial from the viewpoint of the American Dental Association—has been the creation of a new position: Dental Health Aide Therapist. The dental therapist is trained to provide basic restorative and preventive services, including fillings and extractions. Advocates say that dental therapists will help people who can't afford what dentists charge or who live in remote areas where no dentists have offices. The ADA argues that only dentists are qualified to extract or prepare teeth. It should be noted that the Dental Health Aide Therapist position is modeled after a program begun in New Zealand in 1921 and now operates in over 50 countries.

The first experiment with using a dental therapists program in the United States was launched in Alaska in 2003 under the authority of the Alaska Native Tribal Health Consortium, a nonprofit health organization owned and managed by Alaska Native tribal governments and their regional health organizations. The ADA unanimously passed a resolution supporting litigation, should it become necessary, to oppose dental therapists practicing in the Tribal health care system in Alaska. The dentistry board also authorized an advertising campaign up to a $150,000 level "to educate Alaskan natives and others about the risks of allowing non-dentists to perform irreversible procedures." In June 2007, a Superior Court judge for the State of Alaska ruled that Dental Health Aide Therapists have the right to provide dental treatment to Alaska Natives, including preventive and restorative care. The ADA dropped its lawsuit but continues to oppose the use of Dental Health Aides in restorative care.

On the whole, the nation's oral health has improved dramatically, but a shortage of dentists, lack of fluoridation, and poverty have put rural citizens at a dental disadvantage.

Currently there are programs utilizing dental therapists only in Alaska and Minnesota. Oregon passed a bill last year that allows for a pilot program, and while planning is underway, the program has not yet begun. There is legislation to create dental therapist programs pending in Washington, Vermont, Kansas, New Hampshire, Maine, and California.

On average, Americans have seen significant improvements in oral health over the last 50 years but averages include all conditions along a continuum. If we look at the continuum closely, we can begin to recognize gaps in health and well-being: low-income and rural citizens have less health insurance, are less likely to have flouridated water, receive less dental health care and experience more dental decay and tooth loss.

Dental costs amount to a small percentage of medical costs overall, but failure to deal with them can lead to serious—and very expensive—problems. It's evident by now that private dental practice is not always financially viable in rural areas. This means that the dental health of rural Americans will have to be addressed by government or philanthropic forces. Even as extending medical care to the uninsured remains a contentious issue, is the nation ready to listen up and heal the "silent epidemic"?

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State Legislative Update 2012

Doreen Chamberlin, Executive Officer, Bureau of Oral and Health Delivery Systems

The 84th General Assembly of Iowa has ended, and bills key to the Iowa Department of Public Health (IDPH) were signed by the governor in late May. While IDPH remained relatively stable in funding, the governor exercised some veto powers within appropriations legislation.

Senate File 2336

The Health and Human Services budget bill included vetoes to segments of the bill relating to the Iowa Department of Human Services budgeting practices, specifically to Medicaid budgeting, Iowa Veteran's Home reporting, and funding for the Food Bank of Iowa. None of the vetoes directly impacted IDPH.

State funding for bureau programs was kept primarily at status quo except in safety net programs. The Iowa Collaborative Safety Net Provider Network saw funding increased by almost $400,000. In turn, the Direct Care Worker Initiative received a modest increase of about $34,000. The University of Iowa's College of Dentistry also received $25,000 for the provision of primary care dental services to children in Iowa.

Senate File 2315

Other legislative directives to the Bureau of Oral and Health Delivery Services (OHDS) include mental health redesign. Within this legislation IDPH is directed to convene a mental health workforce development workgroup to identify strategies to address workforce shortages in mental health providers.

House File 2165

This legislation addresses the physician orders for scope of treatment (IPOST) form as an adjunct to advanced medical directives in Iowa. The IPOST form is intended for individuals who are frail and elderly or who have a chronic, critical medical condition or a terminal illness. OHDS is directed to add the form to the IDPH website for statewide access to this resource.

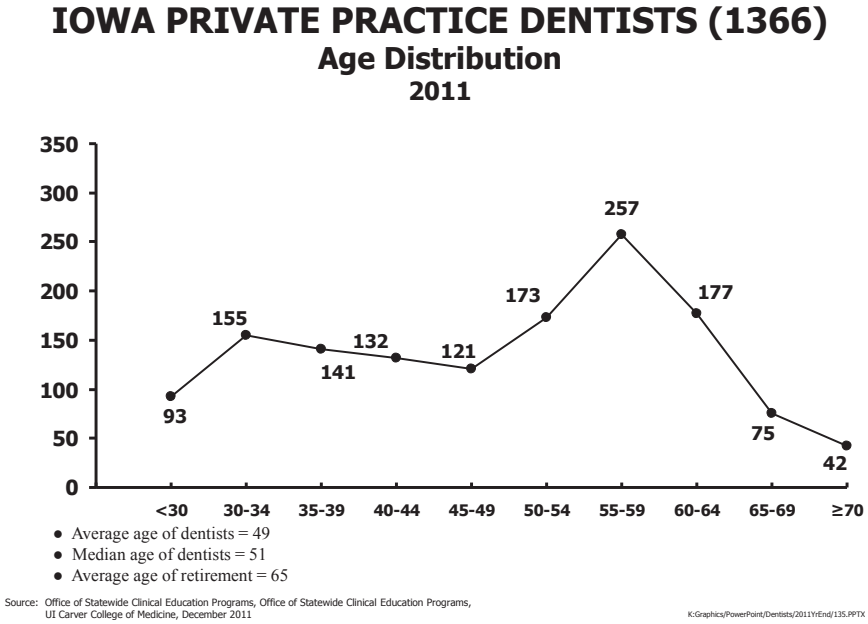
The Farm Progress Show Returns to Iowa

The Farm Progress Show (FPS) has been described as the Super Bowl of agriculture. This year's show will be August 28–30, 2012, at the biannual site just east of Boone near the intersection of Highway 17 and Highway 30. The FPS web site is http://farmprogress.com/farm-progress-show.

The Iowa Department of Public Health Occupational Health and Safety Surveillance Program is again coordinating the Health and Safety Tent Area. Stop by to experience the many demonstrations, displays, and free materials and products. Highlights will include:

- Grain bin safety with rescue demonstrations
- Grain dust explosion chamber display
- Well water testing
- Driving simulator van, rail crossing safety, and rural roadway safety displays
- Cancer awareness and skin cancer screening
- Farm Safety/Child Safety survey with free Marilyn Adams book *"Rhythm of the Seasons, a Journey Beyond Loss."*
- ATV safety with tilt trailer and daily focus groups
- Iowa Healthiest State Initiative and Blue Zones Project
- Heat awareness and farming first aid
- Health care options for adults and children

For more information, contact Kathy Leinenkugel at 800-972-2026 or kathy.leinenkugel@idph.iowa.gov.



The accompanying graph shows the current age distribution of Iowa's active private dentists. The state had 1,366 private dentists at the close of 2011. Note that 607 of the dentists (44%) are in three 5-year intervals from age 50 to 64. Within that group, 257 are in the age range of 55 to 59. Given that the average age of retirement for Iowa dentists is currently 65, the state can anticipate a much higher volume of retiring dentists over the next 5–10 years and beyond. So, to increase our overall supply of dentists—which is already difficult to achieve—Iowa will first need to offset a substantial increase in expected retirements during the next decade.

Source: Office of Statewide Clinical Education Programs, UI Carver College of Medicine, December 2011

Worth Noting

Iowa Rural Health Association – Jerry Karbeling Award Call for Nominations

In honor of the late Jerry Karbeling, the Iowa Rural Health Association will recognize an individual who has demonstrated successful activism for improving rural health and who has as commitment to community service. For more information, click here.

Nominations are accepted until August 1, 2012.

Why Use Swing Beds? Conversations with Hospital Administrators and Staff

In a study conducted by North Carolina Rural Health Research and Policy Analysis Center, hospital administrators and staff were interviewed about the use of swing beds. Topics included the role of swing beds in patient care, swing bed volume, financial considerations, swing beds in the context of all community post-acute skilled care, and swing beds as a benefit for community residents. To read the report, visit http://www.shepscenter.unc.edu/research_programs/rural_program/pubs/finding_brief/FB105.pdf.

Rural Health Fellows Program – The National Rural Health Association

The National Rural Health Association is accepting applications for a year-long fellows program. The goal of the fellows program is to educate, develop and inspire a networked community of rural health leaders who will step forward to serve in key positions in the National Rural Health Association, affiliated rural health advocacy groups and local and state legislative bodies. The rural health fellows meet in person three times throughout the year to undergo intensive leadership and advocacy training. In addition, fellows take part in monthly conference calls to supplement their training, receive updates on legislative and regulatory concerns that impact rural health, and participate in a mentorship program with current members of the NRHA Board of Trustees. Fellows should be committed to advocating on behalf of rural health and should be dedicated to the NRHA's mission. For more information, visit http://www.raconline.org/funding/details.php?funding_id=1628&utm_source=health&utm_medium=email&utm_campaign=update061112.

Continuity and Resiliency for Health IT Systems: Preparing for Unforeseen Events

Staff members from the George C. Grape Community Hospital in Hamburg, Iowa, were presenters for the HRSA Health IT and Quality webinar on April 27. The webinar provided expert advice on how health information technology can help primary care and rural inpatient providers prepare for and overcome an unforeseen event like a flood power outage, snowstorm, or an influenza outbreak. The webinar can be viewed at: https://www.youtube.com/watch?feature=player_embedded&v=xukfiFcNzBk#.

Resources

Improving Antipsychotic Appropriateness in Dementia Patients

The University of Iowa, Iowa Geriatric Center's website includes information and resources to help clinicians, providers, and consumers better understand how to manage problem behaviors and psychosis in people with dementia using evidence-based approaches. The training toolkit includes brief lectures, written content, quick reference guides for clinicians and providers, and information for families or patients on the risks and benefits of antipsychotics for people with dementia (e.g. Alzheimer's disease). Continuing education credit for prescribers, nurses, and pharmacists is available.

The Iowa Partnership for Patients Program

The Iowa Partnership for Patients (PfP) Program is part of the federal PfP. Coordinated by the Iowa Healthcare Collaborative, it has worked for more than three years to increase quality patient care, strengthen hospital management and leadership, and improve health care cost and outcomes in Iowa. To support the PfP, the Iowa Hospital Association is offering 20 minute webcasts to assist hospitals in achieving their patient quality care goals. Click here for more information.

Iowa Hospital Facts

The Iowa Hospital Association recently developed the interactive Iowa hospital facts tool. It gives information about Iowa's health care system to help people make informed decisions about their health care. For more information, visit http://www.iowahospitalfacts.com.

New Podcast Series about the AHRQ Quality Indicators™ Toolkit for Hospitals

A new series of seven 10-minute audio interviews feature hospital experts explaining how to use the quality improvement tools in the AHRQ Quality Indicators™ Toolkit for Hospitals. The toolkit is a free resource to guide hospitals through the process of using the AHRQ Inpatient Quality Indicators and Patient Safety Indicators to improve care. Visit http://www.ahrq.gov/qual/qitoolkit to check out the toolkit and listen to the podcast interviews.

Wellmark Healthy Communities Grant Program

The Wellmark Foundation is now accepting letters of intent for their Healthy Communities Grant Program – Level I. Funding will seek to facilitate programs targeting childhood obesity prevention initiatives and community-based wellness and prevention. This funding is designed to support smaller projects under $20,000. All letters of intent are due by August 14, 2012. For more information on the Healthy Communities Grant, please contact Matt McGarvey at mcgarveym@wellmark.com or visit http://www.wellmark.com.

Grants Management Training

Polk County Sheriff's Office and Grant Writing USA will present a two-day grant management workshop in Des Moines, Iowa, July 19–20, 2012. This training is for grant recipient organizations across all disciplines. Learn how to administer government grants and stay in compliance with applicable rules and regulations. Click here for full event details.

Calendar of Events

Iowa Rural Health Association: Lunch and Learn Webinar Series

June 28, 2012

The next Iowa Rural Health Association Lunch and Learn Webinar will feature the Supreme Court of the United States decision on the Patient Protection Accountable Care Act. Speakers include Maggie Elehwany, National Rural Health Association, and Keith Mueller, the University of Iowa Department of Health Management and Policy. Registration is at http://www.iaruralhealth.org/index.php/educational-events-mainmenu-34.

Iowa Healthcare Collaborative Events

August 28, 2012 – Hospital Engagement Network – Readmissions Learning Community
August 29, 2012 – Annual Conference
August 30, 2012 - Hospital Engagement Network – Hospital Acquires Conditions Learning Community
For more information, visit http://www.ihconline.org/aspx/publicreporting/iowareport.aspx.

Joint Fall Rural Health Meeting

September 20, 2012

The Iowa Rural Health Association and Iowa Association of Rural Health Clinics are hosting this annual meeting on rural health. National and state speakers on rural health issues and promising practices will be featured. Registration will be available the last week of July at http://www.iaruralhealth.org and http://www.iarhc.org.

The AgriSafe Network Webinars

The AgriSafe Network provides monthly training opportunities via the web for organizations and health providers involved with farmers, farm workers, and farm families. For more information and upcoming webinar dates, please visit http://agrisafe.org/training/webinars/.

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OHDS

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Des Moines, IA 50319
(515)242-6383
http://www.idph.state.ia.us/hpcdp/ohds.asp

Save

the

Date

11.15.2012

National Rural Health Day

2012

*Celebrating the **Power of Rural!***

What:

2012 National Rural Health Day

When:

November 15, 2012
Week-long events begin November 12th

Where:

Your local Iowa rural community

Why:

This day gives the opportunity to showcase rural health practices, providers, and communities.
IT WAS A LOT OF FUN LAST YEAR!

More information:

Visit www.celebratepowerofrural.org
MORE DETAILS TO COME!

Sponsored by the Iowa Department of Public Health
State Office of Rural Health

Mobilizing to End Health Disparities

The U.S. Department of Health and Human Services (HHS) has produced the HHS Action Plan to Reduce Racial and Ethnic Health Disparities in response to a community-driven National Stakeholder Strategy for Achieving Health Equity. Together, these plans will guide public and private efforts to reduce disparities in health care and health outcomes.

For more information about the National Partnership for Action, visit: http://minorityhealth.hhs.gov/npa/

We Need Your Support - use the National Partnership for Action: Toolkit for Community Action. The Toolkit will help you:

- **Raise awareness about health disparities** - It includes descriptions of health disparities and their causes.
- **Engage others in conversations about the problem and solutions** - It provides tools to guide efforts to promote programs and policies for change.
- **Take action for change** - It provides information and tools to help individuals and organizations address health in their communities.

Get your National Plan for Action: Toolkit for Community Action at http://minorityhealth.hhs.gov/npa/files/Plans/Toolkit/NPA_Toolkit.pdf

IDPH Iowa Department of Public Health

OMMH
Office of Minority and Multicultural Health
Iowa Department of Public Health