Public Health PBRN
Monthly Virtual Meeting
December 18, 2014

Research in Progress Presentation by the New Hampshire Public Health PBRN:
Exploring Funding Sources, Infrastructure, and Public Health Service Delivery in New Hampshire

Presented by Lea Ayers LaFave, Patrick Bernet, Jo Porter, and Stacey Gabriel

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PUBLIC HEALTH | SERVICES & SYSTEMS RESEARCH
PRACTICE-BASED RESEARCH NETWORKS

at the University of Kentucky College of Public Health

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University of New Hampshire

NH DIVISION OF Public Health Services

Community Health Institute

Exploring Funding Sources, Infrastructure, and Public Health Service Delivery in New Hampshire

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DECEMBER 18, 2014

Partners

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- NH Division of Public Health Services
  - Jose Montero, MD, Director
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- Community Health Institute/JSI
  - Lea Ayers LaFave, RN, PHD
- Technical Assistance:
  - Patrick Bernet, PhD
  - Danielle Varda, PhD

Purpose of the Study

To better understand…

- funding sources and allocations for a key public health focus (tobacco prevention and cessation)
- how to collect data that can be used to do a similar financial assessment for other public health issues and services in the future
- how funding and allocation for services relate to connectivity among partner members of local public health systems

Setting the Context

Small State (pop ~ 1.3M)

"Live Free or Die"

Little formal infrastructure

Lack of tax base

Regionalization:

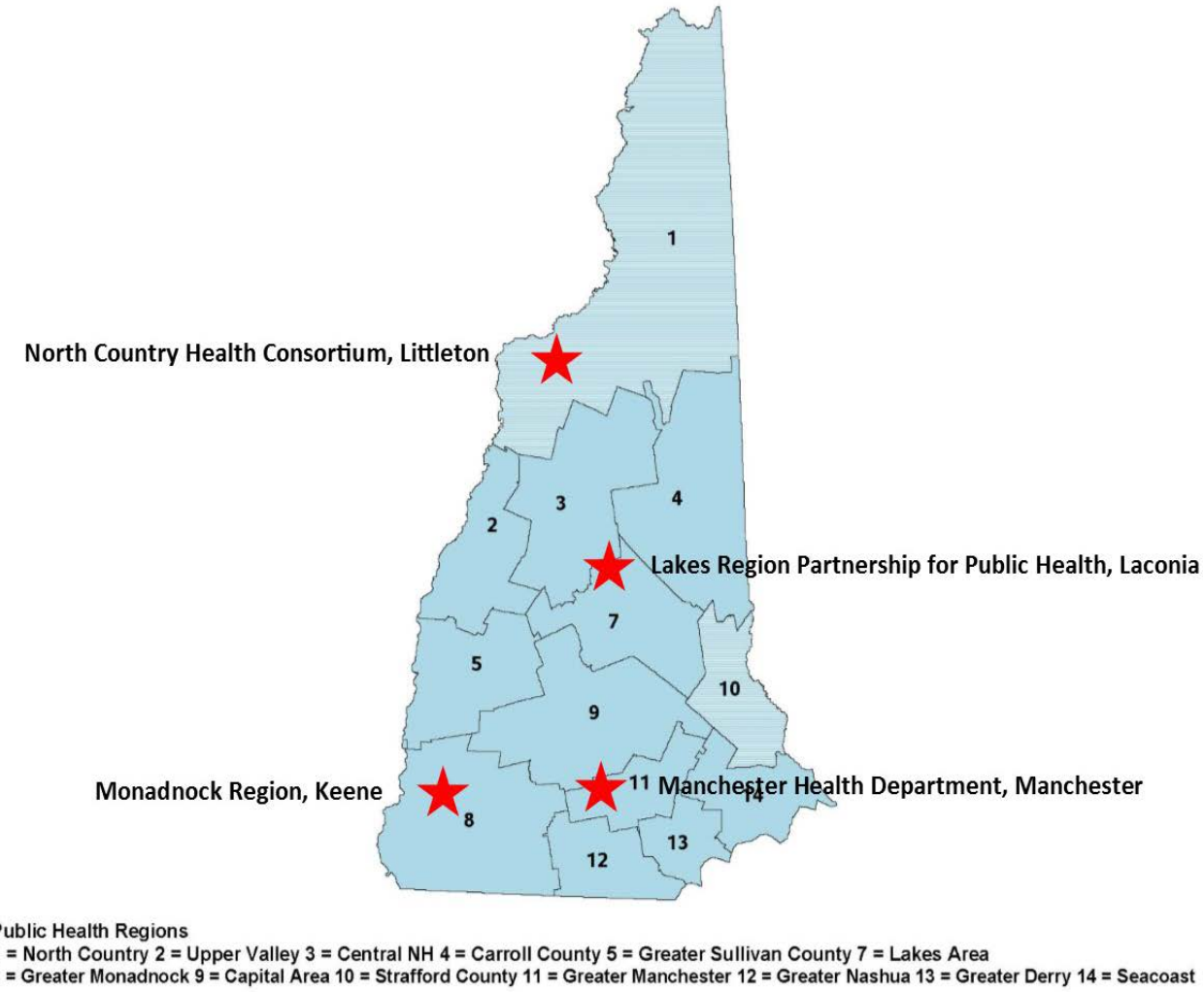
Transformation of the regional public Health system

NH Public Health Infrastructure

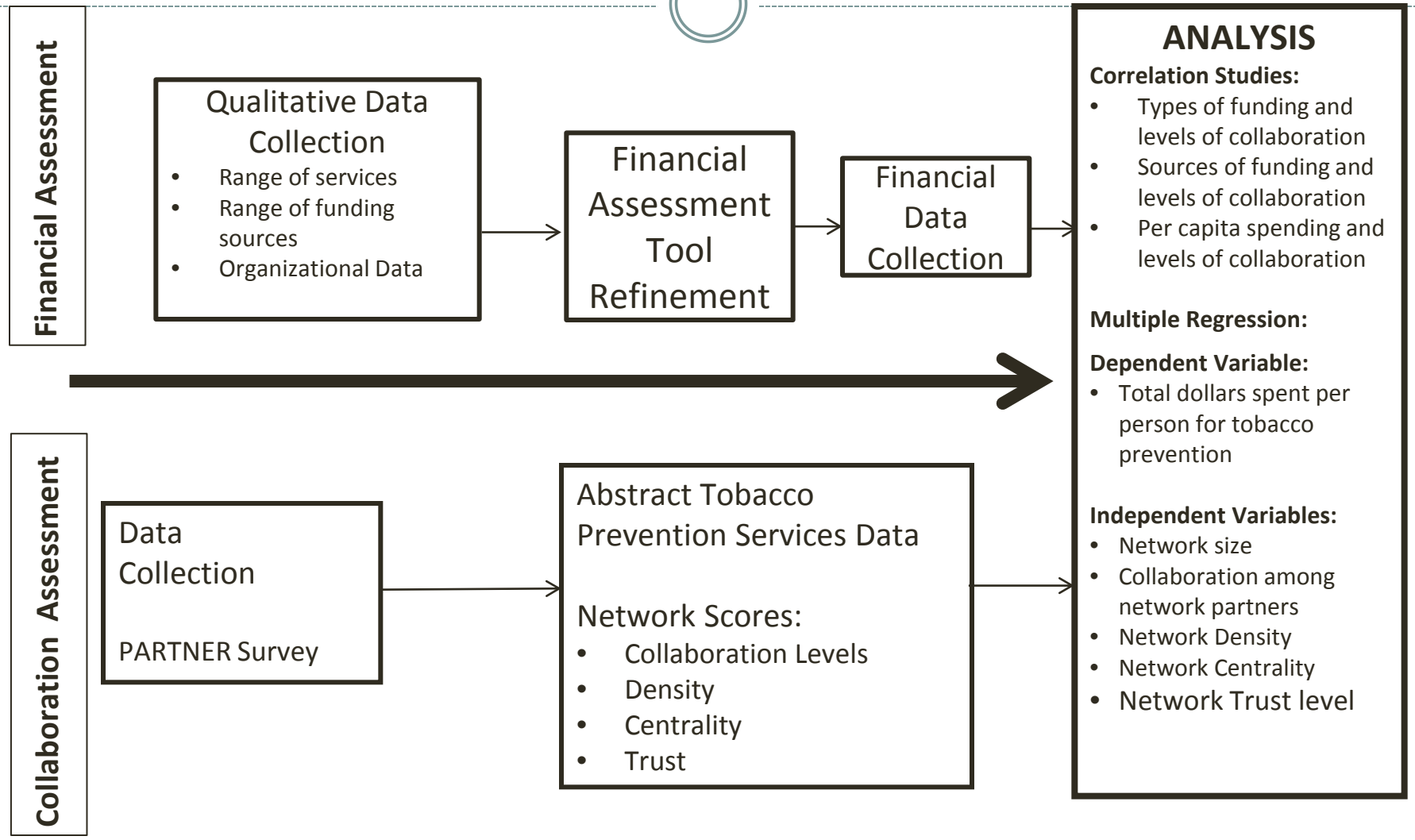
- Local Level
  - 234 cities and towns, Health Officer required by statute
  - 2 Comprehensive Municipal Health Departments
- Regional Level
  - 13 Regional Public Health Networks (RPHN)– evolving
  - Lead organization for each RPHN
  - No county health departments
  - Strong community-level informal public-private partnerships
- State level:
  - DHHS – Division of Public Health Services
- Foundational Work:
  - 2009-2010: Regional Public Health Assessment: PH Capacity, Governance, Financial
  - 2013: Network Assessment: Coordinated Chronic Disease Prevention
  - 2013-2014: Development of Leadership Councils within each Regional Network

Study Location

Covers 416K people
(~ 32% of total population)



Study Design



Methods- Qualitative

- Qualitative interviews
  - Organizational framework / Governance
  - Range of services offered
  - Variability of funding sources
  - How funding flows between organizational partners
- Transcripts analyzed to identify major themes
- Information from the interviews informed the data collection process for the quantitative financial information from the sites

Qualitative Findings - PH Issues

- Tobacco Prevention or Cessation
- Oral Health
- Substance Misuse Prevention
- Obesity Prevention
- Immunization
- Environmental Hazards
- Behavioral Health
- Violence Prevention

Qual Findings- Public Health Functions

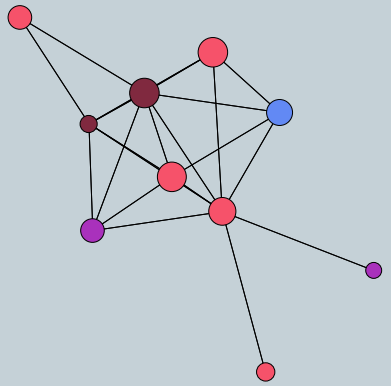
Types of Services Provided	ES1	ES2	ES3	ES4	ES5	ES6	ES7	ES8	ES9	ES10
Health Education			X							
Clinical Integration							X			
Wellness Programs			X							
Care Coordination-Transitions							X			
Insurance Enrollment							X			
Service Coordination							X			
Veteran's Community-based Services							X			
Immigration Program				X						
Public Health Training								X		
Emergency Preparedness		X								
Advocacy					X					
Assessment_Data Resources	X									
Quality Improvement									X	
Convening				X						
Leadership development								X		
Healthy Homes		X								

Methods- Quantitative

- Collected detailed financial information for each site
  - Funding sources and types
  - Amount of Funding
  - Services delivered
- Partner Survey
  - Describe characteristics and levels of collaboration within regional public health systems

Data Collection Template

NCHC Data Collection Tool		*Service Area/Topic*			
		Workforce Development	**Workforce Development**	**Workforce Development**	**Wo De**
Funding Source		Neil and Louise Tillotson Fund of the NH Charitable Foundation	HRSA - AHEC and Public Health Training Center	HRSA - AHEC and Public Health Training Center	HR Ru Po
Funding Type		Private Foundation	Federal	Federal	Fe
Funding Amount By Source		$ 10,926.12	$ 69,231.21	$ 139,374.89	$
Total Funding for Service Area/Topic		$ 417,736.00	$ 417,736.00	$ 417,736.00	$
	Expense Code				
Funding uses		$ 5,799.79	$ 47,927.75	$ 90,379.41	$
Salary & Wages	**5000**	$ 436.59	$ 3,511.26	$ 6,553.20	$
SS & Medicare	**5010**	$ 590.09	$ 5,780.97	$ 7,965.39	$
Employee Benefits	**5030**	$ 37.74	$ 359.25	$ 609.09	$
Workers Comp	**5040**	$ 37.74	$ 1,607.96	$ 2,080.40	$
In-State Travel	**6010**	$ -	$ 69.36	$ 155.22	$



Standardizing Template

Example Public Health Institution

PH Topic Area	Tobacco	HEAL	Public Health Network	Healthy Homes	Workforce Development	Total
Funding Source	Private Non-Profit	Federal				
Funding Type	Grant	Grant				
Funding Amount By Source	$ 201,850.00	$ 138,000.00				$ 339,850.00
Total Funding for Service Area/Topic						
Funding uses						
Salary and Benefits	$ 165,000.00	$ 110,000.00				$ 275,000.00
Consulting	$ -	$ 5,000.00				$ 5,000.00
Food	$ -	$ 250.00				$ 250.00
Misc. Supplies	$ -	$ 100.00				$ 100.00
Office Supplies	$ 5,000.00	$ 1,500.00				$ 6,500.00
Maintenance Contracts	$ -	$ -				$ -
Dues/Subscriptions/Memberships	$ 1,500.00	$ -				$ 1,500.00
Travel	$ 6,700.00	$ 2,500.00				$ 9,200.00
Employee Recognition	$ 500.00	$ -				$ 500.00
Misc. Expenses	$ 900.00	$ -				$ 900.00
Rental/Lease Expenses	$ 2,000.00	$ 2,000.00				$ 4,000.00
Pharmaceuticals (patches)	$ 4,000.00	$ -				$ 4,000.00
Advertising	$ 5,000.00	$ 450.00				$ 5,450.00
Postage	$ 500.00	$ -				$ 500.00
Printing & Duplicating	$ -	$ 1,200.00				$ 1,200.00
Stipends/contract Labor	$ -	$ 13,000.00				$ 13,000.00
Equipment	$ -	$ -				$ -
Training	$ 750.00	$ 2,000.00				$ 2,750.00
Total	$ 191,850.00	$ 138,000.00				$ 329,850.00

Step 1

Step 2

Personnel FTE							Total Personnel FTE
Vice-President Community Health & Clinical Integration							
Director		30%					30%
Family Resource Counselor							
Community Health Program Manager		30%					30%
Community Health Coordinator	100%						100%
Community Health Program Assistant	50%						50%
PHN Coordinator							
Emergency Preparedness Coordinator							
HEAL Coordinator		100%					100%
Program Coordinator							
Tobacco Educator	100%						100%
Director Community Health and Clinical Integration							
Totals	250%	160%					410%

Standardizing Template

PH Topic Area							
Funding Source							
Funding Type							
Funding Amount By Source							
Total Funding for Service Area/Topic							
Funding uses							
Salary and Benefits							
Travel							
Stipends/contract Labor							
Consulting							
Employee Recognition							
Pharmaceuticals (patches)							
Advertising							
Food							
Misc. Supplies							
Postage							
Office Supplies							
Maintenance Contracts							
Dues/Subscriptions/Memberships							
Printing & Duplicating							
Rental/Lease Expenses							
Equipment							
Training							
Misc. Expenses							

Personnel FTE							Total Personnel FTE
Vice-President Community Health & Clinical Integration							
Director							
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Community Health Program Assistant							
PHN Coordinator							
Emergency Preparedness Coordinator							
HEAL Coordinator							
Program Coordinator							
Tobacco Educator							
Director Community Health and Clinical Integration							
Totals							

Standardizing Template

Funding Source				
Funding Type		Totals	Total By Budget Group	% of Total Budget
Funding Amount By Source				
Total Funding for Service Area/Topic				
Funding uses				
Salary and Benefits	**Salary/Wages/ Benefits**			
Travel	**Travel/Meeting**	$ -		
Stipends/contract Labor	**Contractors**	$ -		
Consulting		$ -		
Employee Recognition	**Staff Development**	$ -		
Pharmaceuticals (patches)	**Program Supplies and Costs**	$ -		
Advertising		$ -		
Food		$ -		
Misc. Supplies		$ -		
Postage		$ -		
Office Supplies	**Operations**	$ -		
Maintenance Contracts		$ -		
Dues/Subscriptions/Memberships		$ -		
Printing & Duplicating		$ -		
Rental/Lease Expenses		$ -		
Equipment		$ -		
Training		$ -		
Misc. Expenses	**Other**	$ -		
	Total	$ -		

Personnel FTE		Total Personnel FTE	Total by FTE Group
Vice-President Health & Clinical Integration	Leadership		
Director			
Director Community Health and Clinical			
Family Resource Counselor	Program Staff		
Community Health Program Manager			
Community Health Coordinator			
PHN Coordinator			
Emergency Preparedness Coordinator			
HEAL Coordinator			
Program Coordinator			
Tobacco Educator			
Community Health Program Assistant	Administrative Staff		
Totals			

Standardization Across Sites

Spending Areas	Funding Areas
Salary/Wages/Benefits	Federal
Travel/Meeting	State
Contractors	Private Foundation
Staff Development	Healthcare
Program Supplies and Costs	Business
Operations	Higher Education
Vehicles	
Other	

Summary - Spending Categories

% Total Spending by Category	LRPPH	MHD	Cheshire	NCHC
Salary/Wages/ Benefits	65%	79.0%	38.7%	53.8%
Travel/Meeting Expenses	7%	0.3%	3.4%	1.8%
Staff Development	4%	0.1%	0.1%	1.9%
Contractor	2%	16.0%	29.6%	0.2%
Vehicles	0%	0.2%	0.0%	0.6%
Program Supplies and Cost	9%	2.0%	6.3%	30.2%
Operations	12%	3.0%	6.3%	11.4%
Other	2%	0.2%	15.50%	0%

Total FTE by Group	LRPPH	MHD	Cheshire	NCHC
Leadership	0.40	.75	2.80	0.55
Program Staff	5.95	8	5.50	7.50
Administrative Staff	1.00	.65	0.50	1.30

Summary - Funding Sources

% of Funding by Source	LRPPH	MHD	Monadnock	NCHC
Federal	0%	18.5%	0%	58.0%
State	64%	27.6%	20%	15.0%
Private Foundation	29%	7.3%	57%	19.0%
Municipal	3%	45.8%	0%	0%
Healthcare	1%	0.7%	0%	0%
Higher Education	3%	0.2%	0%	0%
Business	0%	0.0%	23%	7.0%

Federal: HHS, HUD, EPA, HRSA
State: DPHS

Network Data

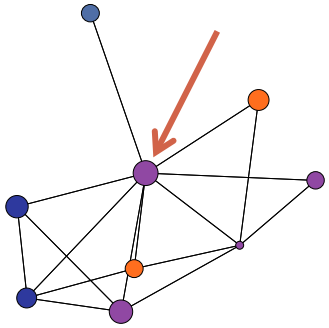
PARTNER TOOL

(PROGRAM TO ANALYZE, RECORD, AND TRACK NETWORKS TO ENHANCE RELATIONSHIPS)

Network Metrics

Network Dimension/ Indicator	Description
Density	% of ties present in the network in relation to the total # of possible ties in the entire network.
Degree Centralization	The lower the centralization score, the more similar the members are in terms of their number of connections to others (e.g. more decentralized).
Trust	The % of how much members trust one another. ▪ Reliability ▪ In support of network mission or purpose ▪ Open to discussion/negotiation 100% occurs when all members trust others at the highest level.

Greater Monadnock Region PH Network



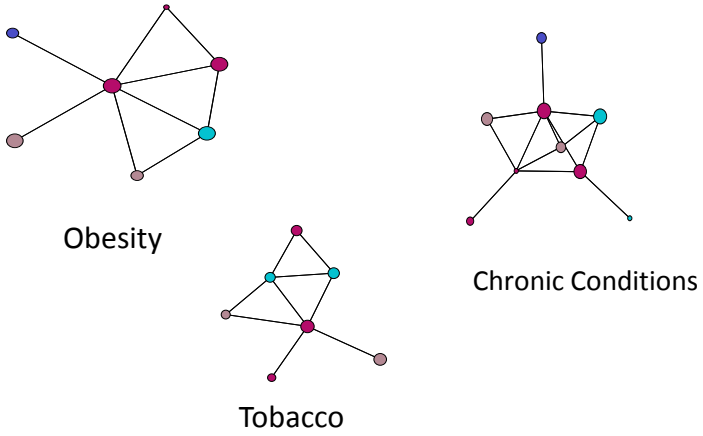
Monadnock Region
Tobacco, Obesity, Chronic Conditions
(n=9)

Total FTE by Group	
Leadership	2.80
Program Staff	5.50
Administrative Staff	0.50

Service Area	N	Density	Degree Centralization	Trust
Municipalities: 32 Population Served: 104,000 Budget FY2013: $ 467,676.00	9	28.7%	54.2%	82.4%

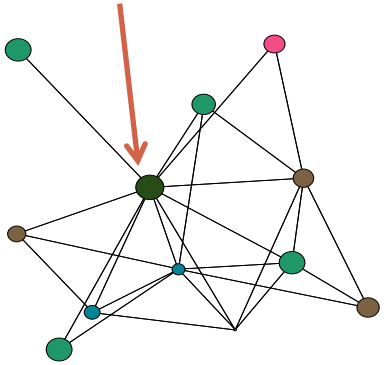
Greater Monadnock Region PH Network

- Strong community-based infrastructure
- Engaged in a community change initiative designed to foster and sustain a positive culture of health throughout the Region



% of Funding by Source	
Federal	0%
State	20%
Private Foundation	57%
Municipal	0%
Healthcare	0%
Higher Education	0%
Business	23%

Manchester Health Department

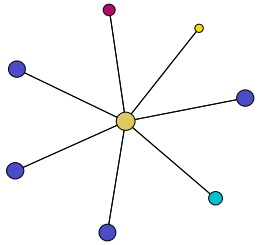


Greater Manchester
Tobacco, Obesity, Chronic Conditions
(n=12)

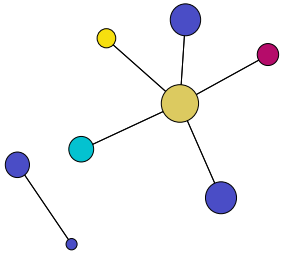
Total FTE by Group	
Leadership	.75
Program Staff	8.0
Administrative Staff	.65

Service Area	N	Density	Degree Centralization	Trust
Municipalities: 8 Population Served: 180,000 Budget FY2013: $3,077,356.00	12	24.3%	66.3%	66%

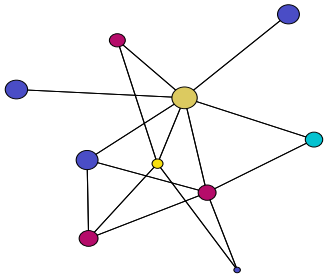
Manchester Health Department



Tobacco



Obesity

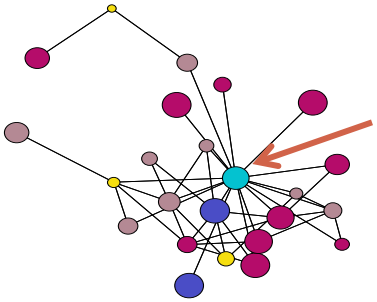


Chronic Conditions

- *"At any time, we'll have at least twenty to twenty-five outside funding sources coming through the department…there's a blending of funding that we get as a department and some of it's clean and very direct and some of it is not."*

% of Funding by Source	MHD
Federal	18.5%
State	27.6%
Private Foundation	7.3%
Municipal	45.8%
Healthcare	0.7%
Higher Education	0.2%
Business	0.0%

North Country Regional PH Network



North Country
Tobacco, Obesity, Chronic Conditions
(n=24)

"We have probably thirty something funding sources. Our funding model really is grant based; we are pretty much all soft money."

- Well-established consortium of partner organizations

Total FTE by Group

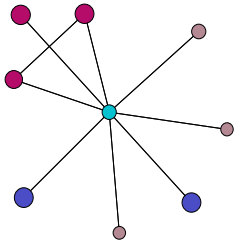
Leadership	0.55
Program Staff	7.50
Administrative Staff	1.30

Service Area	N	Density	Degree Centralization	Trust
Municipalities: 37 Population Served: 52,000 Budget FY2013: $ 1,408,445.35	24	17.6%	74.1%	76.8%

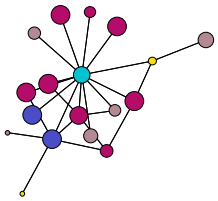
North Country Regional PH Network

- *"…none of these programs could exist alone without the infrastructure of the Consortium behind them because the resources are just too small individually."*

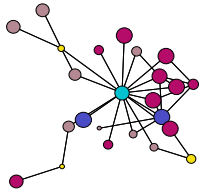
- *"The downside of the type of funding model is that we're often limited because of the demands of the particular funders. You know we try not to be driven solely by the dollar we try to maintain our… being true to our mission but at times its challenging because we are really, often directed by the funds that we receive."*



Tobacco



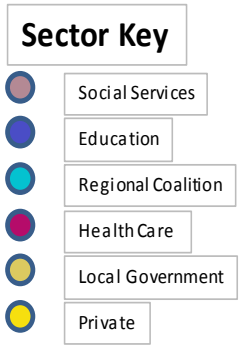
Obesity

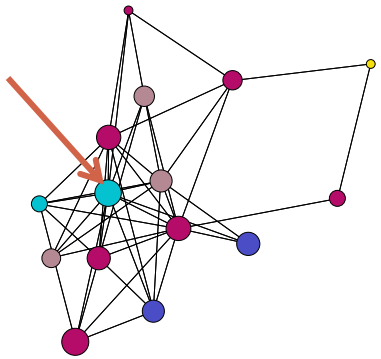


Chronic Conditions

% of Funding by Source	
Federal	58.0%
State	15.0%
Private Foundation	19.0%
Municipal	0%
Healthcare	0%
Higher Education	0%
Business	7.0%

Winnipesaukee Regional PH Network





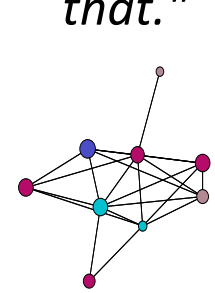
Winnipesaukee
Tobacco, Obesity, Chronic Conditions
(n=16)

Total FTE by Group	
Leadership	0.40
Program Staff	5.95
Administrative Staff	1.00

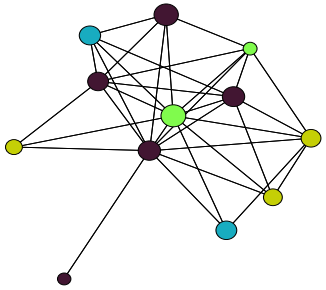
Service Area	N	Density	Degree Centralization	Trust
Municipalities: 16 Population Served: 80,000 Budget FY2013: $ 748,784	16	26.1%	43.8%	74%

Winnipesaukee Regional PH Network

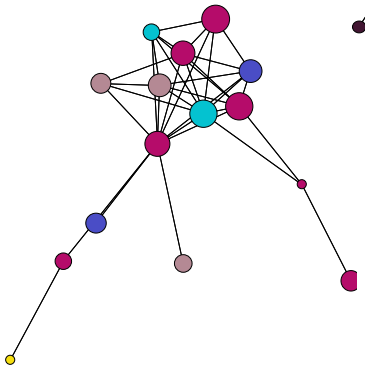
- *"We do a lot of work … because we exist as human beings, not because somebody wrote us a check to do that."*



Tobacco



Obesity



Chronic Conditions

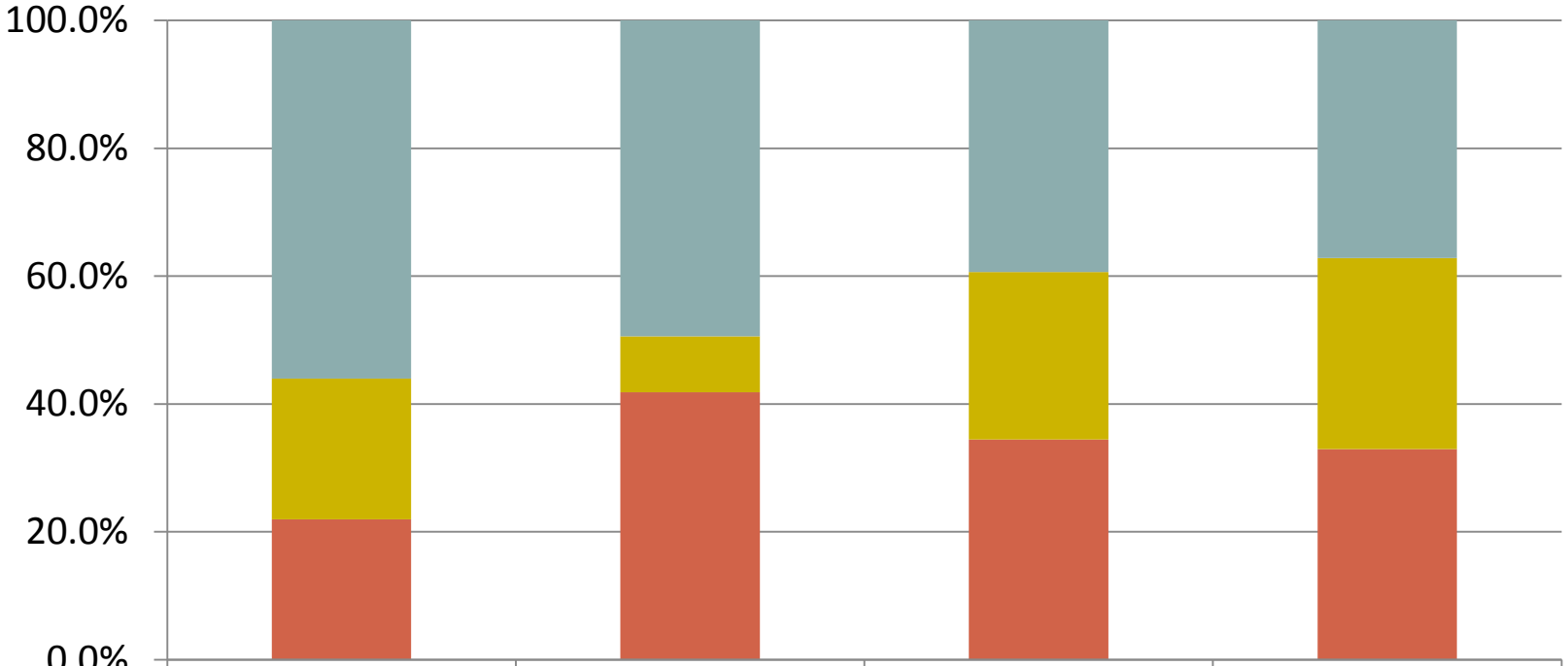
% of Funding by Source	
Federal	0%
State	64%
Private Foundation	29%
Municipal	3%
Healthcare	1%
Higher Education	3%
Business	0%

Collaborative Activity Levels

Cooperative → Coordinated → Integrated

- **Cooperative Activities**: Exchange information, attend meetings together, offer resources to partners. Resources are kept separate. No risk.
  - Example: Informs other programs of RFP release
- **Coordinated Activities:** Intentional efforts to enhance each other's capacity for the mutual benefit of programs. Includes cooperative activities. Requires some planning and division of roles.
  - Example: Separate granting programs utilizing shared administrative processes and forms for application review and selection.
- **Integrated Activities:** Foster interdependence to create unified capacity - a center of knowledge and programming that supports work in related content areas. Includes cooperative and coordinated activities. Requires planning, and sharing of resources and power.
  - Example: Developing and utilizing shared priorities for funding effective prevention strategies. Funding pools may be combined.

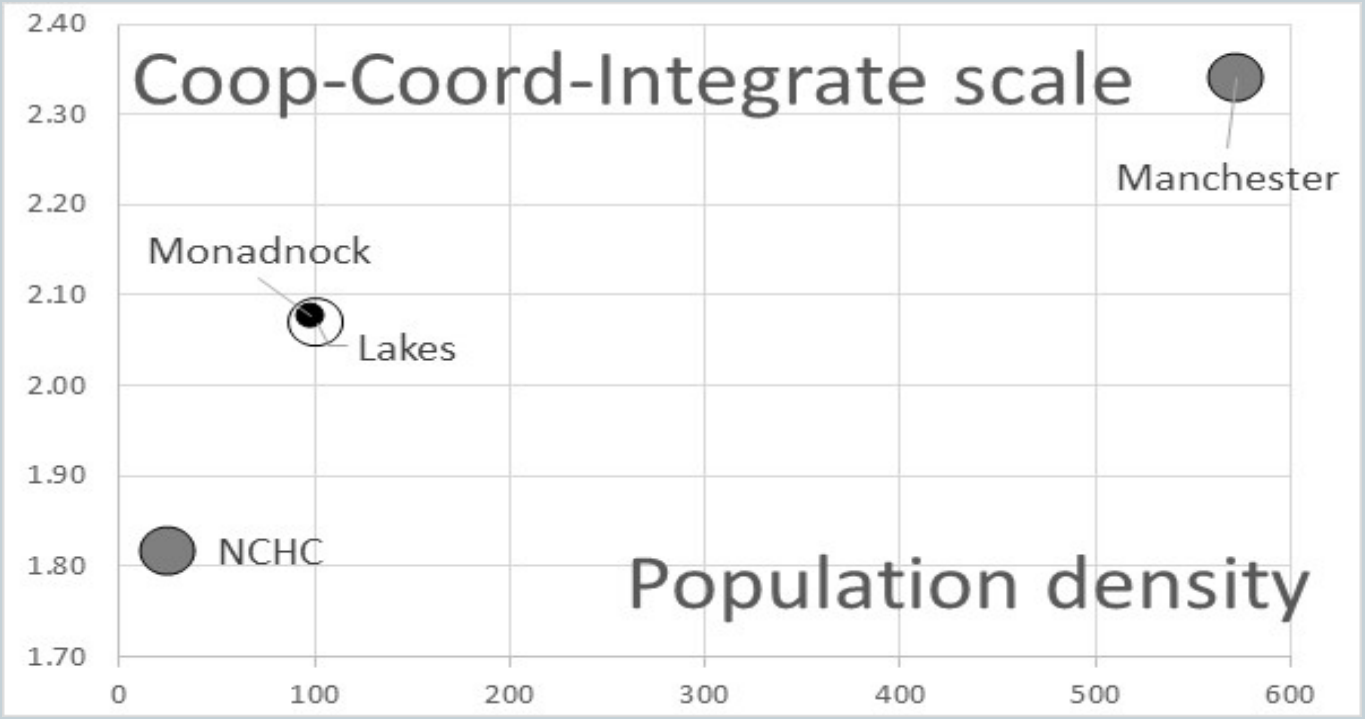
Collaborative Activity Levels Across Regions



	Manchester	Monadnock	NCHC	Winnipesaukee
Integrated	56.1%	49.4%	39.4%	37.2%
Coordinated	22.0%	8.7%	26.2%	29.9%
Cooperative	22.0%	41.8%	34.4%	32.9%

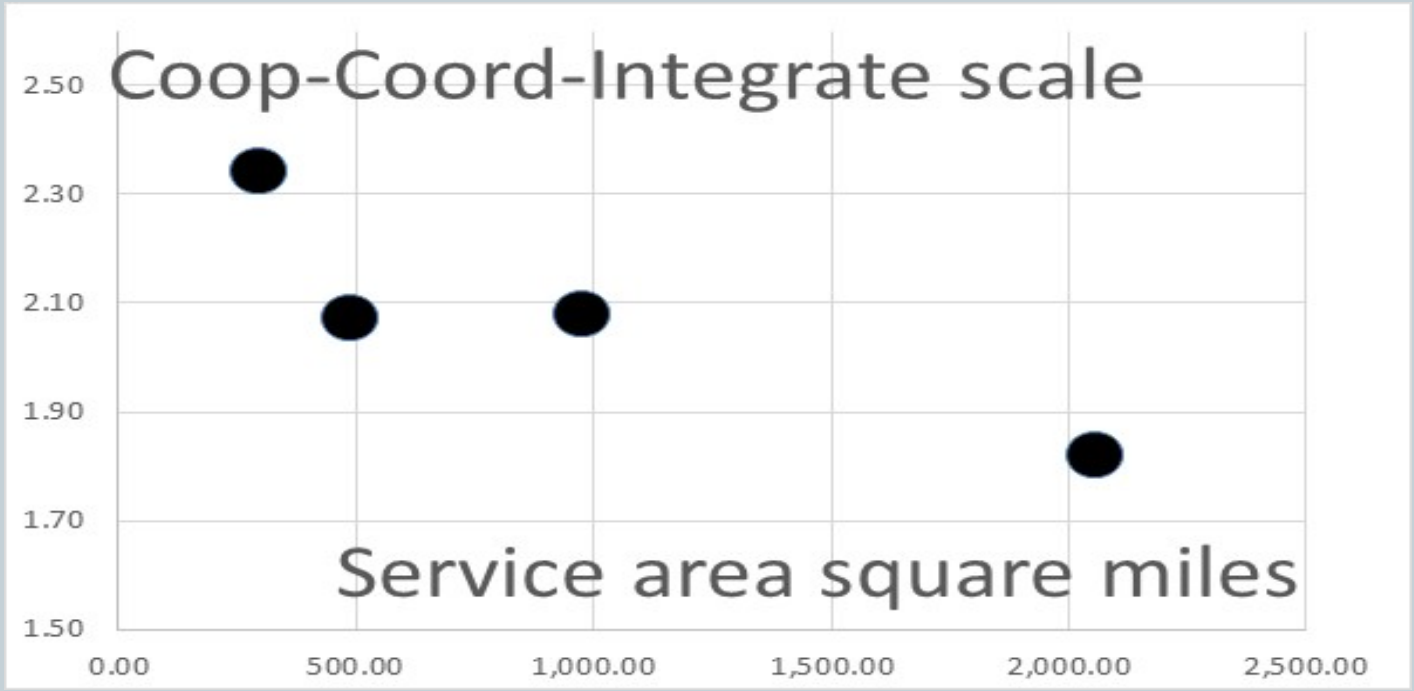
Financial / Network Analysis

Population Density and Network Measures



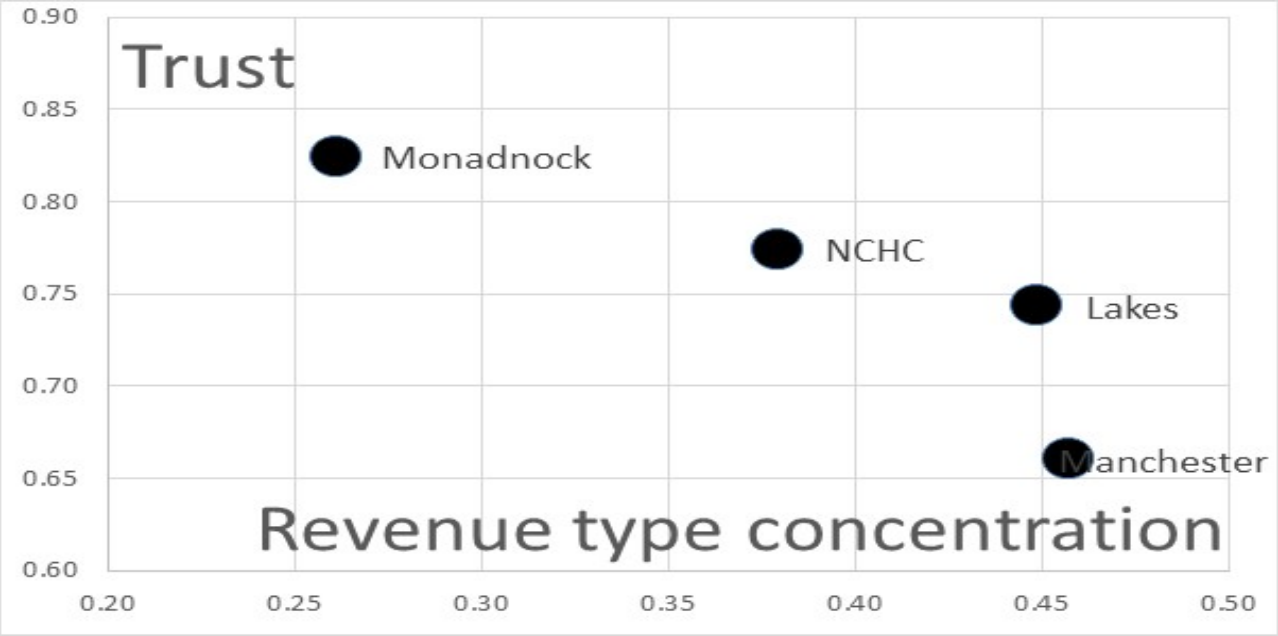
- LHD networks are more integrated in densely populated areas.
  - Densely populated areas ➔ more interpersonal interaction ➔ public health concerns (like flu).
  - Short distance between participants ➔ more activities can be efficiently shared.

Service Area Size and Network Measures



- Larger geographic area ~ lower levels of collaborative activity.
  - Physical distance ➔ fewer interactions that form bonds.
  - Physical distance ➔ fewer activities for which collaboration makes financial sense.

Revenue Type Concentration and Network Measures



- Greater concentration of revenue sources
  ~ lower levels of trust.
  - Greater revenue concentration ➔ more competition among nodes for same funding source.

Salaries and Network Measures

- More spending on Salaries & Contracts (at central node):
  - More is done in central node, so less 'need' for inter-node trust (downhill slope of the red triangles Δ).
  - However, with relatively more people, also need higher levels of coordination (uphill slope of the black circles●).

Summary and Final Thoughts (…to date)

- Decentralized system with wide regional variation across all dimensions, including structure
- Developed mechanism to standardize revenue and spending streams
- Main Limitation: network scores reflect the entire network (multiple partners); but financial data reflect the lead public health entity in the region
- Next steps:
  - In process of validating with regions to finalize data
  - Potential for future research: incorporating financial data from each partner organization within each network

Thank you!

Thanks to funding and support of

- Robert Wood Johnson Foundation Practice-Based Research Network in Public Health – Delivery and Cost Studies Grant # 71155
- Public Health Services and Systems Research Coordinating Center

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Coordinating Center Updates

- **Coalition for Evidence-Based Policy's Randomized Control Trial Competition**

  Glen Mays

- **PHSSR Translation Toolkit**

  Cynthia Lamberth

Research Dissemination and Implementation

December 18, 2014 at 1:00-2:30pm EDT

Grantee Reflections from Recent Conferences

Research Dissemination and Implementation Agenda

Moderator: Anna Hoover, PhD National Coordinating Center

Presenters: Grantees will present lessons learned at December conferences

- Disseminating and implementing research results
- To benefit other researchers who are reporting/implementing research results

Mentored Research Development Awardees (2012-14)

- **Jackie McDonald Gibson, PhD**
- **Jenine Harris, PhD**
- **Thad Miller, DrPH**

Questions and Discussion

Research Dissemination and Implementation

What is "Science of Dissemination & Implementation?"

- Resources
  - AcademyHealth Translation and Dissemination Institute
  - NIH OBSSR Dissemination and Implementation page
  - Canadian Institute of Health Research Knowledge Translation Clearinghouse Tools
  - UNC's NC TRaCS Dissemination & Implementation Portal
  - Washington University Center for Dissemination and Implementation
  - 7th Annual Conference on the Science of Dissemination and Implementation Slides

Lessons from:

7th Annual Conference on the Science of Dissemination and Implementation:

Transforming Health Systems to Optimize Individual and Population Health

Research Dissemination and Implementation

Jackie McDonald Gibson, PhD

Assistant Professor, Department of Environmental Sciences and Engineering

Gillings School of Global Public Health

University of North Carolina, Chapel Hill

Research:

Racial Disparities in Access to Public Water and Sewer Service in North Carolina: *Public Health Impacts and Policy Solutions*

Conference:

Society for Risk Analysis Annual Meeting

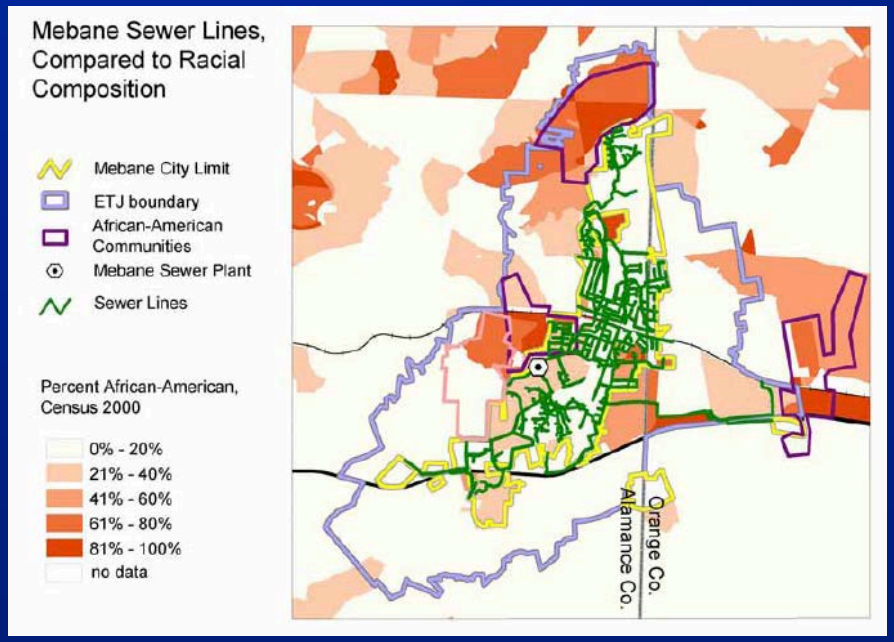
Racial Disparities in Access to Public Water and Sewer Service in North Carolina

- Observations on Research Dissemination and Implementation

- Jacqueline MacDonald Gibson, Associate Professor
- Gillings School of Global Public Health
- University of North Carolina at Chapel Hill

- December 18, 2014

Background: Minority Communities Were Historically Excluded from City Services



SOURCE: Cedar Grove Institute for Sustainable Communities, Mebane, NC

Anecdotal reports: NC African American communities excluded from city services (including water and sewer)

- **Legacy of institutionalized segregation (Jim Crow)**
- **Magnitude of problem not known**

Mebane, NC, example:

- **African American neighborhoods excluded from sewer service**
- **Wastewater treatment plant borders excluded community**

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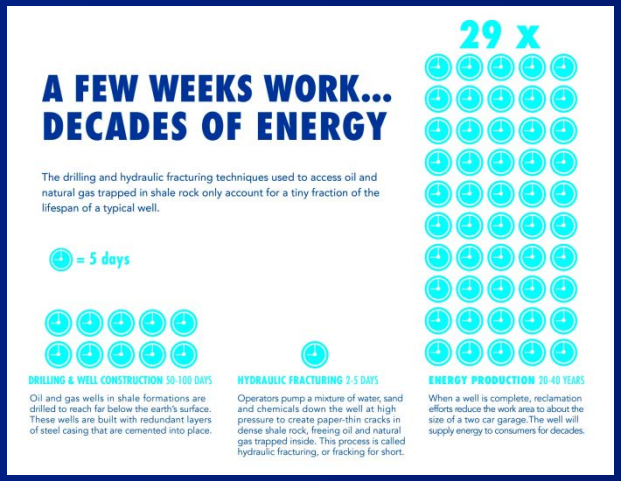
Project Objectives

- Locate NC communities on the fringes of cities and towns that lack public water and/or sewer service.
- Characterize the health risks of lack of service.
- Identifies barriers and solutions to establishing water and sewer services to these communities.

Research Translation Lessons from the Society for Risk Analysis Conference

- "Risk Analysis: The Common Denominator," Denver, Colorado, December 7-11
- Key lesson: pitfalls in communicating risks related to a politically charged subject
- Context: Plenary session on fracking, "Technological Advances, Risk Tradeoffs, and Societal Concerns Associated with Hydraulic Fracking"



SOURCES: energyfromshale.ord; AP photo, Matt Rourke, reproduced at thinkprogress.org

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Plenary Speaker Recommendations for Improving Discourse on Fracking

"Cut back on the shouting and take part in a civil discourse shaped by the consideration of evidence rather than the denunciation of opponents."

1. **Take aim at the key risks.**
2. **"Attend carefully to the genuine distress" of affected communities. Government officials: "Recognize more legitimacy in the concerns of . . . residential neighbors."**
3. **Realize that, on their own, scientific findings will not be able to "chart the route to sound decisions and policies."**

   - **Dr. Patty Limerick, Professor of History and lead for "citizen science" component of University of Colorado fracking study**

Why Is This Relevant to Water/Sewer Service Disparities?

Issue of municipal service disparities remains politically charged.

- **Local politicians: Bristle at accusations of racism.**
  - **Example: Some Wake County officials angered by my research findings, published in *Frontiers in PHSSR*.**
- **Communities: Distrust public officials; have had to resort to civil rights lawsuits.**

SOURCE: Mark Schultz, Raleigh News and Observr

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Possible Research Dissemination and Translation Strategy

- Stakeholder meeting in neutral setting:
  - Members of affected communities
  - Local public utility officials
  - County health departments
  - NC Division of Public Health
  - Local mayors
- Hear concerns of each group; brainstorm solutions; discuss dissemination activities and future needs.
- Possible venue: UNC Water Institute Water Microbiology Conference, May 18-22

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Research Dissemination and Implementation

Jenine Harris, PhD

Assistant Professor in Public Health

Brown School of Social Work

Washington University in St. Louis

Research:

Developing the Evidence-base for Social Media Use in Public Health

Conference:

7th Annual Conference on the Science of Dissemination and Implementation; TA Workshop for Investigators New to D&I Research

A Checklist for Writing Successful Implementation Grant Applications

Jenine K. Harris

(video)

Research Dissemination and Implementation

Thad Miller, DrPH, MPH

Assistant Professor

Department of Health Policy and Management and Department of Medicine

University of North Texas Health Sciences Center

Research:

Applied Economic Modeling for TB Control

Conference:

7th Annual Conference on the Science of Dissemination and Implementation

APPLIED ECONOMIC MODELING FOR TB CONTROL: STRATEGIES FOR DISSEMINATION

THADDEUS L. MILLER, DRPH, MPH

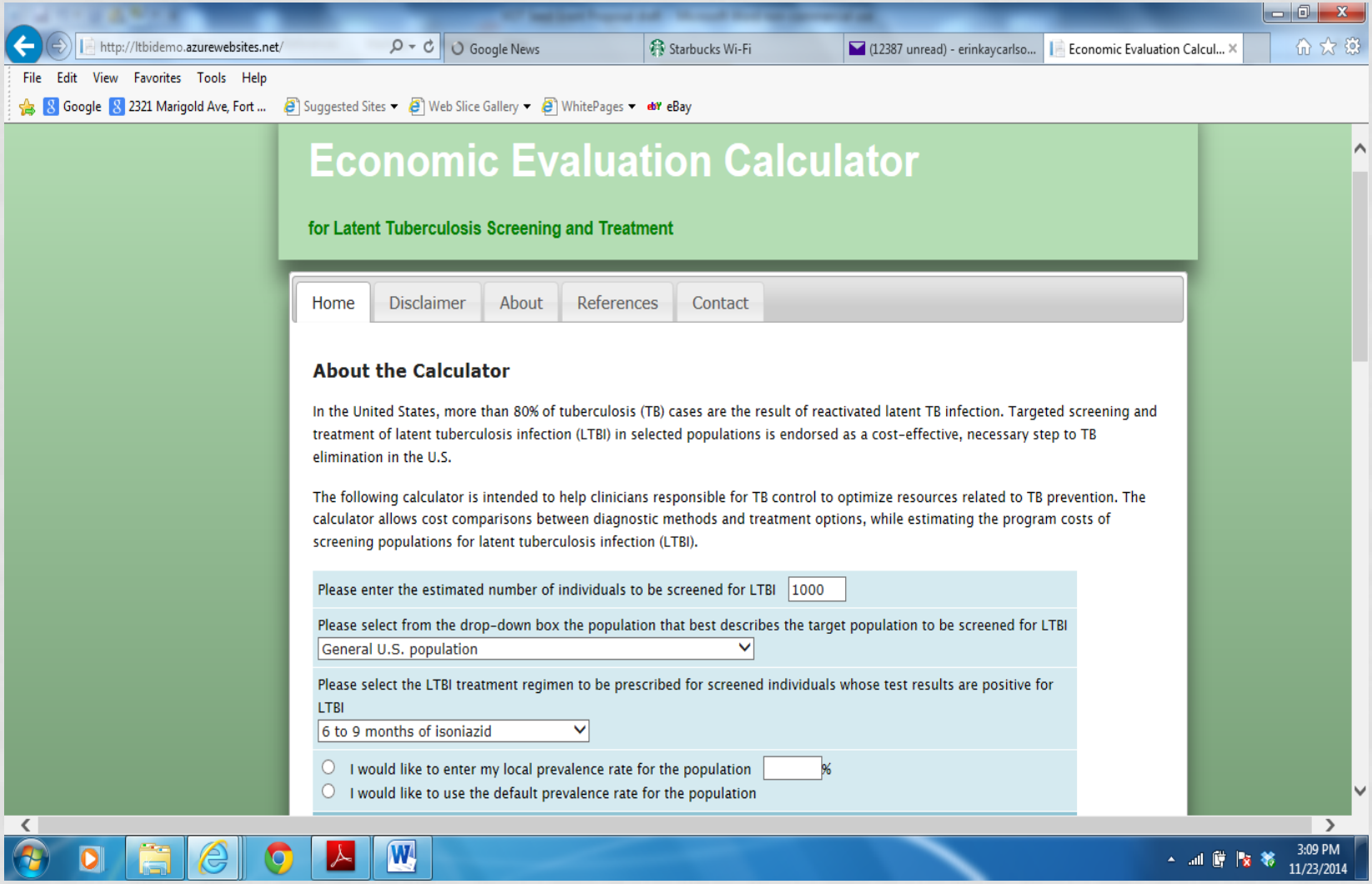
PROJECT SUMMARY

- MRSD grant facilitated application of data/logic from prior projects to local/state PHD needs
  - Models to evaluate relative impacts of TB control activities developed
  - Intended to inform PHD practice
  - Bulky and technically detailed
- We identified significant opportunities for efficiency
  - Recommended scaling back adoption of new technology to carefully targeted populations only
- One year later…
  - Recommendations not followed

EXOVATION: THE DE IMPLEMENTATION OF UNNECESSARY SERVICES

ROUNDTABLE FACILITATED BY AHRQ, UC DENVER, AND NCI

- Vetting health system decisions:
  - What *not* to do as important as what *to* do
- Lessons learned:
  - Incentives matter
  - Local/end-user empowerment
  - Find the right soapbox
    - accessible information/voice
- Moving forward
  - Developed web-hosted application to enable local, individual PHD level decision support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Suggested Sites
Web Slice Gallery
WhitePages
eBay
Economic Evaluation Calculator
for Latent Tuberculosis Screening and Treatment
Home
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About the Calculator
In the United States, more than 80% of tuberculosis (TB) cases are the result of reactivated latent TB infection. Targeted screening and treatment of latent tuberculosis infection (LTBI) in selected populations is endorsed as a cost-effective, necessary step to TB elimination in the U.S.
The following calculator is intended to help clinicians responsible for TB control to optimize resources related to TB prevention. The calculator allows cost comparisons between diagnostic methods and treatment options, while estimating the program costs of screening populations for latent tuberculosis infection (LTBI).
Please enter the estimated number of individuals to be screened for LTBI
1000
Please select from the drop-down box the population that best describes the target population to be screened for LTBI
General U.S. population
Please select the LTBI treatment regimen to be prescribed for screened individuals whose test results are positive for LTBI
6 to 9 months of isoniazid
I would like to enter my local prevalence rate for the population
%
I would like to use the default prevalence rate for the population
3:09 PM
11/23/2014

Questions and Discussion

Closing Thoughts:

- Coordinating Center support for D&I
- PHSSR D&I challenges for 2015

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