PHSSR Research-In-Progress Series:

Bridging Health and Health Care
Wednesday, May 6, 2015 12:00 - 1:00pm ET

CHIP and CHNA: Moving Towards Collaborative Assessment and Community Health Action

Please Dial Conference Phone: 877-394-0659; Meeting Code: 775 483 8037#. Please mute your phone and computer speakers during the presentation. You may download today’s presentation and speaker bios from the ‘Files 2’ box at the top right corner of your screen.
Agenda

Welcome: Angie Carman, DrPH, Assistant Professor, Health Management & Policy, U. of Kentucky College of Public Health

“CHIP and CHNA: Moving Towards Collaborative Assessment and Community Health Action”

Presenters: Scott Frank, MD, MS scott.frank@case.edu and Alexandria Drake, MPH ajd96@case.edu, Ohio Research Assn. for Public Health Improvement (Ohio Public Health PBRN)
Dep’t of Epidemiology and Biostatistics, Case Western Reserve University School of Medicine

Commentary: Rosemary Valedes Chaudry, PhD, MPH, MHA, CPH, RN, Ashland University College of Nursing & Health Sciences
Heidi Gullett, MD, MPH, Case Western Reserve U. School of Medicine, Dep’t. Family Medicine & Community Health

Questions and Discussion
Presenters

Scott Frank, MD, MS, Director

\textit{scott.frank@case.edu}

Alexandria Drake, MPH, Program Manager

\textit{ajd96@case.edu}

Ohio Research Assn. for Public Health Improvement (Ohio Public Health PBRN)

Dep’t of Epidemiology and Biostatistics, Case Western Reserve U. School of Medicine
Better Together?
Hospitals & Health Departments
Public Health & Medicine

Scott Frank, MD, MS
Alexandria Drake, MPH

Ohio Research Association
for Public Health Improvement
Public Health Practice-Based Research Network
No disclosures

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Acknowledgements

แรษิ ทีม
- Katie Gardner, MPH candidate
- Melanie Golembiewski, MD, MPH Candidate
- Sara Tillie, MPH candidate

ฮีพีโอ ทีม
- Reem Aly, JD, MHA, HPIO Director of Healthcare Payment and Innovation Policy
- Amy Bush Stevens, MSW, MPH, HPIO Director of Prevention and Public Health Policy
- Sarah Bollig Dorn, MPA candidate
- Todd Ives, BA candidate
Overview

- Purpose
- Background
- Methods
- Results
  - CHA/CHIP/CHNA/CHNIS Landscape in Ohio
  - Process and Quality
  - Priorities
- Discussants
- Questions, comments
Purpose

To compare and contrast the community health assessment process and priorities led by LHD and by hospitals in Ohio
Key Terms

- Community Health Needs Assessment (CHNA)
- Community Health Needs Assessment Implementation Strategy (CHNIS)
- Community Health Assessment (CHA)
- Community Health Improvement Strategy (CHIP)
- Community Health Assessment and Process and Priority Quality Measurement Tool (CHAPP QMT)
## Importance

### LHD Led CHA/CHIP Documents
- Recent state and national movement to require LHD accreditation
- Efforts are underway to enhance the quality and consistency of CHA/CHIP documents

### Hospital Led CHNA/CHNIS Documents
- Under the Affordable Care Act IRS code section 501(r)(3), most nonprofit 501 (c)(3) hospitals are required to complete a CHNA/CHNIS document

### General
- Little has been done to examine variations in priorities of these documents and how community characteristics may influence these differences
## Importance

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**General**
- Little has been done to examine variations in priorities of these documents and how community characteristics may influence these differences
Compliance: IRS Final Regulations

 CHNA cycles
 “… require the solicitation and consideration of input from persons representing the broad interests of the community anew with each CHNA, even if the CHNA builds upon a previously conducted CHNA.”

 Setting priorities
 “… includes taking into account input in identifying and prioritizing significant health needs, as well as identifying resources potentially available to address those health needs.”

Adapted from Kevin Barnett, DrPH, MCP, May 2015
Compliance: IRS Final Regulations

Documentation of input

- “... require public input on the implementation strategy by requiring a hospital facility to take into account comments received on the previously adopted implementation strategy when the hospital facility is conducting the subsequent CHNA.”

Focus on disparities

- “...a joint CHNA conducted for a larger area could identify as a significant health need a need that is highly localized in nature or occurs within only a small portion of that larger area.”

Adapted from Kevin Barnett, DrPH, MCP, May 2015
Compliance: IRS Final Regulations

Social determinants of health

- “…include not only the need to address financial and other barriers to care but also the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.”

Evaluation

- “…the CHNA report include an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA.”

Adapted from Kevin Barnett, DrPH, MCP, May 2015
189 nonprofit/government hospitals (as of July, 2014)

170 CHNAs

80 ISs

124 local health departments (as of September, 2014)

110 CHAs

65 CHIPs
Cross-jurisdictional LHD CHA/CHIP (n=110)

- 64.5% 1 LHD
- 35.5% Two or more LHDs together

Collaboration among hospitals (n=170)

- 80% Two or more hospital facilities
- 20% one hospital facility
- 63% own hospital system only
- 37% collaborated with at least one hospital outside own health system
Percent of hospitals reporting LHD collaboration on CHNA (n=170)

- No LHD involvement: 11%
- Provided secondary data: 32%
- Partner in data collection: 38%
- Involved in focus groups or key informant interviews: 48%
- Involved in prioritization: 32%
- CHNA partnership: 46%
- CHNA leadership role: 36%
- CHA CHNA joint document: 19%
Percent of LHDs reporting hospital collaboration on CHA (n=110)

- No hospital involvement: 17%
- Provided secondary data: 38%
- Partner in data collection: 34%
- Involved in focus groups or key informant interviews: 18%
- Involved in prioritization: 15%
- CHA partnership: 30%
- CHA leadership role: 34%
- CHA CHNA joint document: 16%
Percent of hospitals reporting LHD collaboration on IS (among hospitals with an IS, n=80)

- IS partner: 19%
- IS leadership role: 14%
- CHIP/IS joint document: 10%
Percent of LHDs reporting hospital collaboration on CHIP (among LHDs with a CHIP, n=65)

- CHIP partner: 19%
- CHIP leadership role: 25%
- CHIP/IS joint document: 6%
Process and Quality

• Compare and contrast the community health assessment process led by LHD and led by hospital

• Introduce the Ohio Community Health Assessment Process and Priority (CHAPP) Quality Measurement Tool
CHAPP Quality Measurement Tool

- Adaptation of Wisconsin CHIPP (Community Health Improvement Plan and Process) Quality Measurement Tool
- Adapted to allow direct comparison between LHD and Hospital community health assessment process
- Examine differences within and between LHD and Hospitals
CHAPP Quality Measurement Tool Items

- Foundational (8)
- Working Together (5)
- Assessment (11)
- Prioritization (5)
- Implementation (10)
- Evaluation (4)

- Total (43)
Process Quality by LHD Type

- Combined: 2.51
- City: 2.2
- County: 1.97

No difference by Board of Health

64% of the LHDs not conducting a CHA were County LHDs.
Process Quality by LHD Jurisdictional Size

No difference by cross jurisdictional CHA CHIP

79% of the LHDs not conducting a CHA were jurisdictions <50k
Process Quality by LHD Total Budget

- **QMT mean**
  - >$2m: 2.32
  - $900k-2m: 1.83
  - < $900k: 2.06

No difference by per capita budget

57% of the LHDs not conducting a CHA had budgets < 900k
Process Quality by Hospital Collaboration

- **Identical**: 2.15
- **90% Identical**: 1.91
- **Small Joint Component**: 1.81
- **One Facility**: 2.00
Hospital Process Quality

No difference by:
- Hospital type
- Financial size
- Net community benefit
- Total beds
- Admissions
- Outpatient visits
- Membership in a group system
LHD-Hospital Process Quality

- Foundational
- Working Together
- Assessment
- Prioritization
- Implementation
- Total

Legend:
- Hospital
- LHD

Ohio RAPHI
### Foundational

<table>
<thead>
<tr>
<th>Foundational Area</th>
<th>LHD</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHA within the past five years/CHNA past 3 years</td>
<td>88.7% (110)</td>
<td>88.4% (167)</td>
</tr>
<tr>
<td>CHIP within the past five years/ CHNIS past 3 years</td>
<td>52.4% (65)</td>
<td>47.1% (80)</td>
</tr>
<tr>
<td>The CHA/CHNA document(s) are electronically available to the public via a website</td>
<td>92.7% (102)</td>
<td>100% (170)</td>
</tr>
<tr>
<td>The CHIP/CHNIS document(s) are electronically available to the public via a website</td>
<td>60.9% (67)</td>
<td>47.6% (81)</td>
</tr>
<tr>
<td>The document acknowledges national priorities</td>
<td>0.9% (1)</td>
<td>68.2% (116)</td>
</tr>
<tr>
<td>The document acknowledges state priorities</td>
<td>11.8% (13)</td>
<td>0.6% (1)</td>
</tr>
<tr>
<td>A formal model, local model, or parts of several models are used to guide the process</td>
<td>72.7% (80)</td>
<td>18.8% (32)</td>
</tr>
<tr>
<td>Specific staff are designated to manage the process</td>
<td>43.6% (48)</td>
<td>13.1% (22)</td>
</tr>
</tbody>
</table>
## Working Together

<p>| Sectors (stakeholders) participate in partnership to develop a comprehensive assessment of the population served by the health department (&gt;4 sectors). | 75.5% (83) | 61.9% (104) |
| Stakeholder participation continues into prioritization process (≥4 sectors) | 54.5% (60) | 49.7% (84) |
| The stakeholders define a purpose, mission, vision, and/or core values for the process. | 80.0% (88) | 19.4% (33) |
| Documentation of current collaborations that address specific public health issues or populations. | 73.4% (80) | 44.1% (75) |
| Guiding principles or shared values identified. | 29.1% (32) | 2.9% (5) |</p>
<table>
<thead>
<tr>
<th></th>
<th>LHD</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health issues and specific descriptions of population groups</td>
<td>48.2% (53)</td>
<td>70.6% (120)</td>
</tr>
<tr>
<td>with specific health issues are described.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health issues and specific descriptions of medically vulnerable</td>
<td>26.4% (29)</td>
<td>46.5% (79)</td>
</tr>
<tr>
<td>population groups with specific health issues are described.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health disparities and/or health equity are discussed.</td>
<td>38.2% (42)</td>
<td>64.9% (111)</td>
</tr>
<tr>
<td>A description of existing community assets and resources to</td>
<td>50.0% (55)</td>
<td>86.0% (147)</td>
</tr>
<tr>
<td>address health issues is presented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is evidence of primary data collection.</td>
<td>95.5% (105)</td>
<td>82.9% (141)</td>
</tr>
<tr>
<td>There is evidence of secondary data collection.</td>
<td>96.4% (106)</td>
<td>99.4% (169)</td>
</tr>
<tr>
<td>Sources of data are cited most or all of the time.</td>
<td>87.3% (96)</td>
<td>91.8% (156)</td>
</tr>
</tbody>
</table>
### Prioritization

<table>
<thead>
<tr>
<th>Statement</th>
<th>LHD</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information from the community health assessment is provided to the stakeholders who are setting priorities.</td>
<td>82.7% (91)</td>
<td>87.1% (148)</td>
</tr>
<tr>
<td>Document(s) include issues and themes identified by stakeholders in the community.</td>
<td>77.3% (85)</td>
<td>92.9% (158)</td>
</tr>
<tr>
<td>Community health priorities were selected using clear criteria established and agreed upon by the stakeholder group.</td>
<td>45.5% (50)</td>
<td>69.4% (161)</td>
</tr>
<tr>
<td>Community health priorities were selected using any criteria established and agreed upon by the stakeholder group.</td>
<td>62.8% (69)</td>
<td>94.7% (161)</td>
</tr>
<tr>
<td>Priorities are easily located on a website and identifiable as priorities by the general public.</td>
<td>50.9% (56)</td>
<td>80.6% (137)</td>
</tr>
<tr>
<td>Description</td>
<td>LHD</td>
<td>Hospital</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>Data is used to inform public health policy, processes, programs, and/or interventions.</td>
<td>50.0% (55)</td>
<td>37.6% (64)</td>
</tr>
<tr>
<td>Identifies any improvement strategies that are evidence-informed.</td>
<td>50.0% (55)</td>
<td>10.6% (18)</td>
</tr>
<tr>
<td>Document(s) contains measurable objectives with time-framed targets.</td>
<td>39.1% (55)</td>
<td>11.2% (19)</td>
</tr>
<tr>
<td>Engage in any activities that contribute to the development or modification of (public) health policy.</td>
<td>34.5% (38)</td>
<td>6.4% (11)</td>
</tr>
<tr>
<td>Action plan exists or is under construction for implementation of strategies in partnership with others and including timelines to implement plan.</td>
<td>42.7% (53)</td>
<td>14.7% (25)</td>
</tr>
<tr>
<td>Identifies whether any individuals and organizations that have accepted responsibility for implementing strategies.</td>
<td>38.7% (48)</td>
<td>16.5% (28)</td>
</tr>
<tr>
<td>Includes priorities and action plans for ≥4 entities beyond the local health department/hospital.</td>
<td>38.7% (48)</td>
<td>26.5% (45)</td>
</tr>
</tbody>
</table>
Key Process Findings

Comparing LHDs
- Quality is better in larger jurisdictions and with larger budgets
- Quality is not influenced by the presence of a Board of Health or conducting a cross-jurisdictional CHA CHIP

Comparing Hospitals
- There is little difference in quality based on hospital structure or financing
Key Process Findings

LHD community health assessment process was more likely to:

- Be grounded in theoretical and evidence based frameworks
- Define a mission or vision
- Include implementation planning
- Have broad stakeholder participation
- Conduct health policy activity
Key Process Findings

Hospitals community health assessment process was more likely to:

- Address community assets
- Address health equity and vulnerable populations
- Choose health priorities using criteria
- Provide community health assessment information to the stakeholders who are setting priorities
Level of LHD-Hospital Collaboration and Process Quality

- None: Hospital 1.59, LHD 1.96
- Moderate: Hospital 1.86, LHD 2.0
- High: Hospital 2.28, LHD 2.51
What Matters in Collaboration?

- No difference in quality
  - Provide secondary data
  - Involve in focus groups or as key informants

- Quality improves
  - Partner in data collection
  - Involved in prioritization
  - Partnership
  - Leadership role
What to Remember...

- LHDs and hospitals bring different skills and perspectives to community health assessment.
- These differences appear to be complimentary.
- Evidence supports that quality of the community health assessment process improves with meaningful collaboration.
Health Priorities

- Health Conditions (11)
- Health Behaviors (10)
- Community Conditions (5)
- Health Systems (10)
<table>
<thead>
<tr>
<th>Health conditions</th>
<th>Health behaviors</th>
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<tbody>
<tr>
<td>Heart disease</td>
<td>Chronic disease (management)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Tobacco use</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>Physical activity</td>
</tr>
<tr>
<td>Obesity</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Cancer</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>Emotional health</td>
</tr>
<tr>
<td>Infant mortality/low birth weight</td>
<td>Youth development/school health</td>
</tr>
<tr>
<td>Oral health</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Injury protection</td>
</tr>
<tr>
<td>Mental health</td>
<td>Family violence</td>
</tr>
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<td>Under-immunization</td>
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<th>Health system conditions</th>
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<td>Build environment (place)</td>
<td>Under-insurance</td>
</tr>
<tr>
<td>Food environment</td>
<td>Access to medical care</td>
</tr>
<tr>
<td>Active living environment</td>
<td>Access to behavioral health care</td>
</tr>
<tr>
<td>Social determinants of health/health equity</td>
<td>Access to dental care</td>
</tr>
<tr>
<td>Community partnership</td>
<td>Bridging public health and medicine</td>
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<td></td>
<td>Quality improvement</td>
</tr>
<tr>
<td></td>
<td>Hospital/clinical infrastructure</td>
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<tr>
<td></td>
<td>Health information technology</td>
</tr>
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<td></td>
<td>Workforce development</td>
</tr>
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<td></td>
<td>Funding/financing/cost of services</td>
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Top 12 hospital and LHD health priorities*

- Obesity: 69%
- Access to medical care: 57%
- Physical activity: 54%
- Addiction: 52%
- Mental health: 51%
- Nutrition: 51%
- Substance abuse prev.: 40%
- Access to Beh. health: 37%
- Diabetes: 34%
- Heart disease: 34%
- Tobacco: 32%
- Infant mortality: 30%

*weighted
Top 10 hospital and LHD health priorities

Hospitals
- Obesity: 69%
- Access to medical care: 59%
- Mental health: 58%
- Addiction: 55%
- Heart disease: 52%
- Diabetes: 50%
- Cancer: 47%
- Infant mortality: 42%
- Physical activity: 39%
- Nutrition: 37%

LHDs
- Physical activity: 70%
- Obesity: 69%
- Nutrition: 64%
- Substance abuse prevention: 57%
- Access to medical care: 55%
- Food environment: 49%
- Addiction: 49%
- Youth development/schools: 46%
- Access to behavioral health: 45%
- Mental health: 44%
Comparison of hospital and LHD priority categories

- Medical conditions: Hospitals 39%, LHDs 24%
- Health behaviors: Hospitals 21%, LHDs 35%
- Community conditions: Hospitals 1%, LHDs 40%
- Health systems: Hospitals 16%, LHDs 20%
Health conditions
Heart disease
Diabetes
Asthma/COPD
Obesity
Cancer
Infectious diseases
Infant mortality/low birth weight
Oral health
Substance abuse (treatment)
Mental health
Under-immunization

Community conditions
Build environment (place)
Food environment
Active living environment
Social determinants of health/Health equity
Community partnership

Health behaviors
Chronic Disease (management)
Tobacco use
Physical activity
Nutrition
Substance abuse
Emotional health
Youth development/School health
Sexual and reproductive health
Injury protection
Family violence

Health system conditions
Under-insurance
Access to medical care
Access to behavioral health care
Access to dental care
Bridging public health and medicine
Quality improvement
Hospital/Clinical infrastructure
Health Information Technology
Workforce development
Funding/financing/cost of services

Key
Obesity cluster
Access cluster
Behavioral health cluster
Cluster Priorities

Medical Condition Cluster: 48
Behavioral Cluster: 37, 29
Access Cluster: 44, 31
Obesity Cluster: 40, 39

Combined Percentages:
- Combined 30%
- Combined 33%
- Combined 37%
- Combined 40%
What to Remember

- Wide variety in the extent of collaboration among hospitals and LHDs across the state
- Collaboration between hospitals and LHDs is associated with higher quality documents
- Hospital health priorities are more likely to focus on medical conditions, while LHDs are more likely to focus on community conditions and health behaviors
- Most prominent community health priorities are related to obesity, access to care and behavioral health
Strengths

- Large, whole sample (n=110 and n=170)
- Comprehensive approach crossing health systems boundaries
- Utilized standard abstraction protocols from adaptation of a previously successful model
Limitations

- Based on information available in documents, not necessarily what was actually done.
- Some items were not effective across LHD-Hospital boundaries and were therefore excluded.
- Analysis based on current stage of assessment, therefore not final products.
Implications for Public Health

The variation between CHA/CHIP and CHNA/CHNIS identified priorities demonstrates important differences in perspective and experience.

The differences appear complementary, implying the population needs would be more effectively served through a collaborative process.
Implications for Public Health

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Better Together!

Comments Questions?
Commentary

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Cuyahoga County Board of Health Population Health Liaison
Heidi.Gullett@case.edu

Questions and Discussion
Archives of all Webinars available at:
http://www.publichealthsystems.org/phssr-research-progress-webinars

<table>
<thead>
<tr>
<th>Upcoming Events and Webinars</th>
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<tbody>
<tr>
<td>Wednesday, May 13 (12-1pm ET)</td>
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<tr>
<td>VIOLENCE AND INJURY PREVENTION: VARIATION IN PUBLIC HEALTH PROGRAM RESOURCES AND OUTCOMES</td>
</tr>
<tr>
<td>Laura Hitchcock, JD, Project Manager, Public Health – Seattle &amp; King County, WA PBRN</td>
</tr>
<tr>
<td>Thursday, May 21 (1-2pm ET)</td>
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<tr>
<td>EXPLORING COST AND DELIVERY OF STI SERVICES BY HEALTH DEPARTMENTS IN GEORGIA</td>
</tr>
<tr>
<td>Gulzar H. Shah, PhD, MStat, MS, Georgia Southern University, GA PBRN</td>
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<tr>
<td>Wednesday, June 3</td>
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<td>Wednesday, June 10</td>
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<td>Thursday, June 18</td>
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<td>Wednesday, July 1</td>
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Thank you for participating in today’s webinar!

For more information:

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