Partner With Nonprofit Hospitals to Maximize Community Benefit Programs’ Impact on Prevention

**Current Status:**

In order for a nonprofit hospital to be exempt from federal income tax, they are required to provide community benefit. This is currently interpreted to mean providing community benefit programs — to support the health and public good of the community they serve. As of a review in 2009, a majority of community benefit funds were used to help pay for care for the uninsured or underinsured — supporting charity care, uncompensated care, means-tested payer discounted care and Medicare shortfalls represented approximately 72 percent of hospitals’ community benefit activities, while community health improvement and community building activities only represented approximately five percent of community benefit activities.\(^1\)

More than half of the hospitals in the United States — 2,900 — operate as nonprofits, and the value of their combined tax exemption is estimated to be as high as $21 billion annually.\(^2\) Nonprofit hospitals were estimated to receive a yearly total of $12.6 billion in tax benefits at the federal, state and local levels in 2002, which would be $16.2 billion in 2012 dollars.\(^3\)

Since the passage of the Affordable Care Act (ACA), every nonprofit hospital is now required to report that, either during the tax year beginning after March 23, 2012 or during one of the two immediately preceding tax years, it has conducted a community health needs assessment (CHNA) and adopted an implementation strategy to address the identified needs of the community it serves. Guidance issued by the Internal Revenue Service (IRS) in 2011 addresses these new requirements: 4

**Assessment:** Every hospital must conduct or access a CHNA on a triennial basis, designed to help hospitals understand the needs of the community it serves. The CHNA report must include 1) a definition of the community the hospital serves; 2) a description of the needs identified and the process for prioritizing needs; 3) a description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA; 4) a description of the process, methods, sources and dates of the data used to conduct the assessment; and 5) a description of the consultation process and a list of community organizations and members and experts consulted, including public health experts, to conduct the assessment. Hospitals may base their CHNAs on information collected by other organizations, such as government agencies or not-for-profit groups, and may conduct CHNAs in collaboration with others.
Each hospital is required to adopt an implementation strategy — a written plan that addresses each of the community health needs identified in the CHNA. The plan should identify the needs the hospital plans to address and those it does not along with the reason why. The strategy should also describe any collaborative efforts the hospital participates in to address certain needs. Hospitals must attach a copy of the most recently adopted implementation strategy to its IRS Form 990.

**Transparency:** The CHNA must be made “widely available to the public” and the U.S. Secretary of the Treasury is directed to undertake a triennial review of the community benefit activities of each hospital receiving tax-exempt status.

The instructions for the 2011 IRS Form 990, Schedule H expanded the kinds of activities hospitals can participate in to satisfy their community benefit requirement — including community building activities, such as programs that support physical activity and nutrition programs in communities, as long as they meet all of the criteria of community health improvement programs.5

### Why the New Community Benefit Requirements Matter:

- The new requirements provide an opportunity for nonprofit hospitals across the country to re-evaluate and reconsider their current approach to community benefit programming, and assess how increased attention to community health improvement and prevention can help improve the health of their patients and lower health care costs. The requirements:
  - Provide new opportunities for nonprofit hospitals to partner with state and local health departments, local employers and businesses and community groups to increase their understanding of the needs of the community;
  - Encourage the development and implementation of effective, coordinated and non-redundant initiatives to improve community health; and
  - Foster policy and system changes that can help coordinate the activities of the broader health care delivery system and create healthier places for Americans to live and work.

### Recommendations:

- **The IRS should take steps to ensure that nonprofit hospitals maximize the advantages of the community benefit requirement.**

  **Expand the scope of hospitals’ use of community benefit dollars:** The IRS should make clear to hospitals that any evidence-based activities that fall within the four strategic directions of the National Prevention Strategy — 1) clinical and community preventive services; 2) healthy and safe community environments; 3) empowered people; and 4) elimination of health disparities — will give the hospital community benefit credit.

  **Encourage hospitals to participate in multi-sector collaboration throughout the process:** For instance, hospitals can collaborate with other hospital organizations within their geographic region, public health agencies, community-based health care and social service organizations, private businesses, philanthropy and other government agencies and programs when developing and executing their CHNA implementation strategies.

  **Ensure transparency of hospitals’ community benefit activities:** Just as their assessment plans are required to be made more transparent, hospitals’ implementation strategies should be made “widely available.” Similar requirements should be implemented, including requiring them to be included on the hospitals’ website and subjecting them to strict transparency requirements, including being able to be viewed, downloaded, printed and accessible without a fee.

- **Nonprofit hospitals should use the new rules to evaluate and re-assess how they spend their community benefit resources.**

  **Hospitals should direct community benefit funds to evidence-based community prevention programs to improve health and lower costs:** Nonprofit hospitals should increase their support for programs outside of the hospital that target the specific health needs of their communities, particularly high-impact, high-cost problems such as those that lead to high rates of emergency room and readmission visits. Funding community prevention programs outside of the hospital will lead to a healthier population and, therefore, fewer people being admitted to the hospital for uncompensated care, lowering long-term health care costs.

  **Hospitals can strengthen their commitment to, and the public’s awareness of, their mission:** As hospitals are required to make information about their community benefit efforts publicly available, they should ensure that they are providing programs that will be recognized by their communities, their employees and their families as supporting the hospital’s mission.
How It’s Working:

Boston Children’s Community Asthma Initiative (CAI) has led to a return of $1.46 to insurers/society for every $1 invested; an 80 percent reduction in the percentage of patients with one or more asthma-related hospital admission; and a 60 percent reduction in the percentage of patients with asthma-related emergency department visits in FY 2011. Boston Children’s Hospital implemented the CAI — a nurse and community health worker model — to provide additional support to improve the health of children with moderate to severe asthma in targeted Boston neighborhoods.

CAI began serving asthma patients from targeted neighborhoods who visited the ER or who were hospitalized. The initiative provides a home environmental assessment and asthma management and medication education, while working with the family and child’s health care providers to remove barriers to improve asthma control. A nurse also partners with community organizations, day care centers and schools to provide asthma education out in the community for parents and caregivers.

Boston Children’s Hospital’s Approach to Community Health: Using programs to achieve systemic change

By M. Laurie Cammisa, Vice President for Child Advocacy and Elizabeth R. Woods, MD, MPH, Director of the Community Asthma Initiative

Boston Children’s Hospital does not have a community “benefits” mission. It does, however, have a community “health” mission that takes the hospital’s community partnerships and activities beyond compliance with state and federal regulations for community benefits and creates health and social impact by addressing the most pressing health needs facing the children of Boston and beyond.

An innovative approach

In the early 1990s, the Attorney General for the Commonwealth of Massachusetts (MA AG) released new guidelines that called for hospitals to rethink their roles in meeting the health needs of their local communities. The processes of assessment and planning that were outlined in the MA AG’s guidelines were recently mandated for all tax-exempt hospitals in the federal 2010 Affordable Care Act and in guidance from the IRS. While the regulations specify the actions that nonprofit hospitals throughout the country must take to achieve compliance, they also leave room to explore the ways in which hospitals can contribute to a changing health landscape.

At Boston Children’s, what started as a response to regulatory requirements has evolved and matured into an innovative approach to advancing the hospital’s community mission. This process began with the hospital’s decision in 1994 to make community the fourth part of its mission in addition to clinical care, research and teaching.

The goal of the hospital’s community mission today is two-fold: (1) partner with key community-based organizations to focus our collective resources in addressing the most pressing health needs of children and families in the local community, and (2) provide services through program models that not only benefit children locally but also...
will also lead to systemic change. The hospitals seeks to accomplish these goals with an emphasis on promoting innovation to achieve social and health impact locally and contribute to systemic change throughout the health care system.

Since the very beginning, conversations and input from community residents and stakeholders have formed the backbone of Boston Children’s approach to identifying and understanding which local and health-related issues are most important for families today. The hospital’s formal needs assessment, conducted every three years, includes a review of best practice literature, an analysis of health data, and an assessment of current community needs and strengths. It also involves focus groups with community residents and interviews with key stakeholders. In its last formal needs assessment in 2009, Boston Children’s interviewed 29 stakeholders, held focus groups with 91 community residents, and conducted these activities in two languages.

Ultimately, the community needs assessment enables Boston Children’s to focus on how the hospital’s clinical expertise and resources can most effectively address the most pressing needs of children and families, as well as reduce gaps in current services and programs.

One of the major challenges faced by any hospital in fulfilling its community mission is how to leverage limited resources to meet an almost limitless amount of need. Over time, Boston Children’s determined that it could provide the greatest impact if it focused its efforts on a select few health issues in which it could work to produce measureable results. The hospital chose to focus its strategy on those issues that fall at the intersection of identified community needs, existing hospital expertise and available community partnerships. Based on this principal, the hospital’s priority focus areas are the health issues of asthma, obesity, child development and mental health.

Central to the hospital’s efforts to carry out its community mission is its collection of programs and partnerships referred to as the Portfolio to Achieve Health and Social Impact. This portfolio consists of four programs that seek to bring innovation to some of Boston’s most pressing health issues: asthma, child development, mental health and obesity. It also includes three strategic partnerships with key organizations in the city of Boston — the Boston Public Schools, the Boston Public Health Commission and community health centers — to strengthen the infrastructure for child health throughout Boston. The hospital manages and measures these programs and partnerships with the goal of demonstrating new models to improve child health throughout the city, state and beyond.

The hospital manages this Portfolio with a triple focus.

One focus is to guarantee that the hospital’s investment of resources (human and financial) is targeted to programs that address local needs, alleviate health disparities, partner and engage with our community and provide services through models that lead to systemic change.

Another is to ensure that, by employing a uniform set of standards and criteria, these programs measure value and social impact — things like improving health outcomes and quality of life, proving cost-effectiveness and building community capacity.

A third is to align with the hospital’s overall need to excel in a changing health care environment. The hospital fits our focus areas and interventions into a continuum of care model that looks for ways to prevent short- and long-term illness and eliminate or avoid medical costs. By doing so, the community health programs are setting the stage for a number of key elements of national health care reform, including reductions in medical costs, the patient-centered medical home and population health management.

One program in the Portfolio, the Community Asthma Initiative (CAI), provides an illustration of this innovation — addressing a health need, delivering services locally and then measuring health and social outcomes to initiate changes that will affect the broader community.

Community mission in action: The Community Asthma Initiative

Boston Children’s had been tackling the issue of asthma for years through clinical services and community-based efforts to help educate families and caregivers on how to best manage the disease. Asthma is the most common admitting diagnosis for children, not only at Boston Children’s but across the nation in pediatric settings. Analysis of admission rates revealed that 70 percent of patients with asthma-related hospitalizations at Boston Children’s came from the neighborhoods immediately surrounding the hospital. In those communities, Black and Latino children had four to five times the admission rate of white children.

Results from Boston Children’s 2003 community needs assessment confirmed what the hospital and other providers and experts already knew first-hand. Asthma was taking a toll on families in Boston neighborhoods. More needed to be done to better manage this condition in order to prevent its damaging consequences — poor health status, loss of work for parents and caregivers and missed school days for children, not to mention additional stress and poor quality of life for the whole family.

Drawing on lessons learned in the clinical setting and earlier community-based intervention efforts, the hospital implemented the CAI in 2005 to provide more intensive support to improve the health of children with moderate to severe asthma in the Boston neighborhoods of Jamaica Plain, Roxbury and Dorchester. CAI began serving patients from the targeted neighborhoods who visited the emergency department or who were hospitalized because of an asthma exacerbation, as those children were most likely to have poorly controlled asthma. The program was not meant to replace the role of primary care providers, but rather be an additional partner and support in helping a family to manage their child’s every day asthma care and connect patients more closely with their Medical Home.

CAI, which is a nurse and community health worker model, establishes a close relationship with the participating families and provides case management services depending on a child’s unique medical and social needs. The initiative provides a home environmental assessment and asthma management
Community Asthma Initiative by the Numbers in FY11

- CAI has reached 908 families since the program was established.
- Conducted 39 educational workshops for 683 parents and providers in the community.
- 76 percent of the families participating in the program have received home visits.
- 80 percent reduction in the percent of patients with any (one or more) asthma-related hospital admission.
- 60 percent reduction in the percent of patients with any asthma-related emergency department visits.
- 41 percent reduction in the percent of patients with any missed school days.
- 46 percent reduction in the percent of parents/caregivers with any missed work days.
- For every $1 spent on the program, $1.46 is returned to society/insurers and $1.73 to society.

Changing asthma care beyond Boston

From the program’s inception, Boston Children’s formed partnerships with asthma advocacy and community organizations to not only address the issue but show that this type of intervention could reduce hospitalizations and emergency room admissions, saving money for the community and insurers.

As the program began to demonstrate success, Boston Children’s looked for ways to expand CAI’s reach to benefit more children than it could through its own direct services. Thus in 2007, the hospital’s Office of Government Relations partnered with the Asthma Regional Council (a coalition of federal and state health, environment, education and housing agencies) to develop a white paper for cost-effective asthma interventions. Based on experiences and outcomes from CAI, “Investing in Best Practices for Asthma: A Business Case” was written and disseminated urging payers to provide children with access to asthma services such as CAI. This sparked further work with other key partners, the Boston Healthy Homes and Schools Collaborative (BHHSC) and the Massachusetts Asthma Advocacy Partnership (MAAP), to use the business case to advocate for policy changes that would help ensure that all children in Massachusetts could benefit from enhanced asthma care.

After three years of advocacy, the efforts were successful in persuading the legislature to earmark $3M in the FY11 Medicaid budget to fund and evaluate a demonstration project that would provide case management services for children with poorly controlled asthma. Medicaid then set up an Asthma Bundled Payment Advisory Committee to develop the plan with Boston Children’s and other advocacy partners serving on the committee. Recently, the Medicaid office approved funding for the proposed pilot program and plans to issue a request for proposals to select six pediatric practices to participate.

The impact of CAI is now poised to reach children and families beyond Massachusetts. CAI is providing technical assistance to the American Academy of Pediatrics which is preparing to replicate the model in Alabama. Ohio is also investigating the approach and plans to implement a similar type of intervention.

CAI represents what Boston Children’s hopes to accomplish with its community mission, providing services locally in partnership with others to address health needs, while also validating that community-based models can be cost-effective solutions for public health problems. Through all of its community efforts, Boston Children’s aims to show how a hospital can go beyond compliance with its community benefit investments, using its community mission as a way to unite other providers, community organizations, advocates, policymakers and families to initiate long-lasting and significant changes for the greater good.

For more on Boston Children’s unique approach to its community mission and the Portfolio for Health and Social Impact, visit www.BostonChildrens.org/community.
A Menu Approach to Public Health: Empowering People to Take Responsibility for their Health Choices

By Tracy Neary, Director of Mission Outreach and Community Benefit, St. Vincent Healthcare

For nearly twenty years, St. Vincent Healthcare, a care site operated by the Sisters of Charity of Leavenworth Health System (SCL Health System), the Billings Health Clinic and RiverStone Health, our local health department, have been working together to address complex community wide health issues by adopting intervention strategies identified through a recurring CHNA.

A significant early collaboration came in 1994 when the CHNA showed access to prescription medications was a major issue for our community. We created a medication assistance program (MAP) that helped patients who couldn’t afford prescriptions obtain them. Last year, MAP advocates, funded in part by St. Vincent Healthcare, assisted approximately 1,200 people with accessing medication worth more than four million dollars. What began as a single access point has expanded to a dozen locations across our community.

The initial collaboration, which began in the early 1990s, between the three organizations became more formal with a Memorandum of Understanding in 2001 to create “The Alliance.” Chief executives of our two competing hospitals and the public health department committed organizational expertise in planning, communication, advocacy, community benefit and clinical services to help lead community efforts to improve health.

Through a CHNA, we found there was a significant need for mental health services, as hospital emergency departments were being inundated with people who didn’t really need medical care but were admitted because of a mental health crisis. Knowing that emergency rooms are not typically the best place for mental health interventions, we created a joint partnership with the two hospitals to build the Community Crisis Center (CCC), the first licensed out-patient crisis management program in Montana.

Now, the CCC is staffed 24 hours per day, seven days per week with a combination of registered nurses, licensed mental health therapists, and mental health technicians. During an outpatient visit, clients are stabilized and assessed to facilitate the development of a crisis management plan.

The CCC has successfully reduced inappropriate utilization of local emergency departments, decreased the number of short-term inpatient hospital admissions, and has been a driving force in reducing the inmate population at the Yellowstone County Detention Facility.

Additionally, the CCC offers crisis intervention training to law enforcement officers in the region. Officers learn how to recognize mental health distress and de-escalate individuals rather than interacting with people in a way that escalates anxiety. Law enforcement officers credit the training with helping them more effectively respond to situations involving individuals with mental health disorders, especially those in suicidal situations.

One of our crisis intervention program officers, off duty at the time, was driving across a bridge and a man was on it threatening suicide. The officer was able to talk the person down without anyone getting hurt. This is one example of how a community program has a wide-reaching public health benefit. Instead of the individual hurting
himself and/or others, no one was hurt and the appropriate part of our community’s medical system (the mental health portion versus an emergency department) was involved.

In 2005, RiverStone Health underwent an assessment of the public health system’s performance in the 10 Essential Public Health Services established by CDC. The assessment was conducted using the National Public Health Performance Standards Program (NPHSPSP), also established by CDC. A key outcome of that assessment was an understanding of the need to perform a community health assessment and develop a community plan. The Alliance then sponsored the 2006 CHnA where childhood and adult obesity, heart disease, diabetes, nutritional intake, unintentional injury, and chronic depression were identified areas of weakness. Physical activity, nutrition, and well-being were selected as the areas of improvement because of their inter-connectedness and their collective benefit on our community’s health. The results moved us to thinking about longer term population health improvements through policy, system and environmental change strategies. We began by creating an operational work plan, “The PItCH.”

The Plan to Improve the Community’s Health (PITC) focuses on physical activity, nutrition, and well-being. PITC is intended to increase awareness and knowledge of, as well as access to, healthier lifestyles in Yellowstone County. This plan was developed with a broad variety of community stakeholders who participate in achieving the identified goals as part of a broad coalition. With the support of the Robert Wood Johnson Foundation, one of the most impactful early Health Impact Assessments (HIA) we completed was with our city/county master growth plan. Results of the HIA led to the adoption of a new health section within the plan in 2008, which set the foundation for later success in adopting a complete streets policy for Billings. This accomplishment was supported in large part by our work with Action Communities for Health, Innovation, and EnVironmental ChangE (ACHIEVE).

As one of the ten original participants in the Healthy Weight Collaborative, a project of the National Initiative for Children’s Healthcare Quality (NICHQ) and HRSA, we partnered with primary care providers to better document body mass index (BMI) in medical records and, if a BMI was too high, offer a patient-directed healthy weight plan. The efforts have created new collaboration between providers and community organizations.

The partnership has also launched an effort into the worksite by developing physical activity and nutrition guidelines. We found that it is important to create a menu approach of evidenced-based practices that have been shown to increase physical activity (i.e., promoting use of stairwells, on-site exercise classes, etc.). The menu option allows businesses to pick and choose which policies are appropriate in their environment and also empowers employers.

A similar project, the “Healthy By Design” (HBD) endorsement, was developed as a way of promoting events in Billings that are designed with health in mind. This endorsement is done through an application process and each application is reviewed and evaluated by a team of experts. There are five criteria: safety; nutrition; physical activity; prevention and wellness; and environmental stewardship.

As we look to the future and our interconnected health system, we see a community that is Healthy By Design with active people working to improve their own health and the health of those around them. It is a dream we plan to realize by continuing our work to identify unmet health needs and leading efforts to coordinate a community based response. We recognize the critical importance of key stakeholders in economic development, private business, city government, education, strategic planners in addition to traditional health partners. Our website, www.healthybydesignt Yellowstone.org includes our CHNA, work plans, accomplishments and a variety of tools we have developed to achieve our vision.
It Takes a Community to Prevent Prescription Drug Abuse

By Laura Fitzpatrick, Drug Free Program Manager and Advocacy Liaison, Muskegon Community Health Project

Founded in 1997, the Muskegon Community Health Project (MCHP), the local community benefit office of Mercy Health Partners hospital, is nationally known for their health access initiatives which are steeped in community collaborative groups. Muskegon’s collaborative has 65 members from 38 local organizations including those from public health, education, law enforcement, court officials, substance abuse agencies, and health care, student organizations, and a variety of community based organizations.

At the outset, MCHP focused on tobacco and alcohol, forming the Tobacco Reduction Coalition and the Muskegon Alcohol Liability Initiative, an alcohol prevention law enforcement taskforce under the Coalition for a Drug Free Muskegon County. The coalition began by sponsoring smoke-free restaurant and workplace initiatives, which ultimately paved the way for a smoke-free Michigan. They also worked on policy, student education efforts, and enhanced law enforcement efforts for both alcohol and tobacco, resulting in substantial declines in student use. Both community-led and supported initiatives steered many youths away from tobacco and alcohol use and abuse and helped them remain happy and healthy.

After several years focusing on alcohol and tobacco, our community turned its attention to prescription drug abuse prevention. The Coalition for A Drug Free Muskegon County, which was originally funded in 2005 from the Substance Abuse and Mental Health Association’s (SAMSHA) Drug Free Communities (DFC) program, conducted a youth survey in 2009 that found that 17.4 percent of youth were trying medications that were not prescribed to them due to easy access. In addition, our law enforcement members reported an increase in residential break-ins especially by those seeking prescription drugs.

At the same time, other groups started looking at “take-back” programs that allow people to get rid of unneeded and unwanted drugs safely with no questions asked. Take-back programs are supported nationally by the ONDCP as excellent opportunities to reduce access to controlled substances. In addition, Lakeshore Health Network, the local physician member service organization, began investigating ways to provide education to physician offices on how to monitor prescription drug use and abuse.

As multiple community organizations and resources were focused on take-back programs and prescription drug abuse, we quickly recognized an opportunity to serve multiple purposes with a single process. In September 2009, the Muskegon Area Medication Disposal Project (MAMDP) met for the first time, establishing the Many communities throughout the country take advantage of federal prevention funding that comes in the form of community building and collaborative organizing through the Office of National Drug Control Policy’s (ONDCP) Drug Free Communities Support Program. The premise of the DFC program is simple – that communities around the country must be organized and equipped to collaboratively deal with their individual substance abuse problems in a comprehensive and coordinated manner.

DFC is a collaborative initiative, sponsored by ONDCP, in partnership with SAMHSA, which works to achieve two goals:

- Establish and strengthen collaboration among communities, public and private non-profit agencies, and Federal, State, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance use among youth.
- Reduce substance use among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse.

DFC grantees are required to work toward these two goals as the primary focus of their Federally-funded effort and they use a variety of ways to achieve local change in their respective communities. While the program offers direction and guidance to its grantees, it is up to the community on how they will achieve the change.
need to address this issue. The solution was to create several opportunities for our community to dispense with their drugs safely and securely.

MAMDP held our inaugural event in February of 2010 at a local fire station. We were overwhelmed by the public’s response: 150 participants dropped off 500 pounds on the first day. Since then, we have hosted 11 events at multiple fire stations, established permanent drop sites throughout the county and collected over three tons of medications.

Of the 7,300 pounds of materials collected in the past two years, 30 percent was over the counter medications, approximately 18 percent comprised cardiovascular medications, 10 percent were diabetic medications and 10 percent, or 810 pounds, were controlled or unknown substances. We also collected 475 pounds of sharps or used needles.

In addition to collecting, we took the process one step further by counting and classifying everything we collected to help inform and then change consumer, systems and local practices when it came to prescribing drugs. We wanted to reduce the source of medications, which would reduce the ability to abuse these prescriptions. We also conducted participant surveys of those dropping the medications off to inform media messaging and better serve the community.

In 2011, the Muskegon Area Medication Disposal Project established permanent multiple collection sites at area pharmacies and law enforcement agencies which now provide a more sustained approach. The future local project continues to build upon its successes and strives to keep educating the community and connecting with local resources.

“The numbers tell a compelling story that you have a hard time disputing,” says Joe Graftema, PharmD, Mercy Health Partners Inpatient Pharmacy Manager and a long time MAMDP leader who coordinates the substance counting and classifying at the one day events. “We’ve been able to inform physicians, hospital leaders, pharmacists and health plan managers who can and have changed their practices or policies.”

At a recent physicians education seminar put together by the project partner Lakeshore Health Network, the MAMDP members were encouraged by the physician response.

“We were impressed at the engagement and interest that the doctors had in changing their prescribing behaviors based upon the information from our disposal project” said MAMDP Chair Carrie Utthe. “They were so surprised about the amount of waste that unused medications were creating and the other safety and environmental issues.”

For more information go to www.MCHP.org
ENDNOTES


