WELCOME!

- We will begin shortly.
- **Please type your name and email into the chat box for attendance.**
- Reminder, we will be recording this session.
- Please mute your line upon entering and chat in your comments or questions.
- Vicki Flanagan will monitor the chat box and call on you to unmute yourself.
- If you have trouble connecting, please email **karen.g.lee@hitchcock.org**

NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NH DIVISION OF Public Health Services Improving health, preventing disease, reducing costs for all

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Text 603-346-4334

Enter Activity Code: **drPy** *(Good for this Live Session Only)*

Need help? **clpd.support@hitchcock.org**
Signing in on-line? **http://www.d-h.org/clpd-account**

Our presenters have no conflicts of interest to disclose.

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ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NH AIM/ERASE Maternal Mortality Webinar
May 13, 2021 (12 – 1PM)

Operationalizing Screening and Intervention for Social Determinants of Health

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Agenda

- Welcome!
  - ERASE-Maternal Mortality (ERASE-MM)
  - NH- Alliance for Innovation in Maternal Health (NH-AIM)
- Screening and providing support to patients with Social Determinants of Health Needs
  - Screening
  - Response
  - New opportunities for reimbursement
- Examples from two New Hampshire maternity care providers
- Discussion: Barriers, facilitators, identified needs, next steps for NH-AIM

Critical Collaborations

Alliance for Innovation on Maternal Health moves established guidelines into practice with a standard approach to improve safety in care

Maternal Mortality Review Committees conduct detailed reviews for complete and comprehensive data on maternal deaths to prioritize statewide prevention efforts

Perinatal Quality Collaboratives mobilize state or multi-state networks to implement clinical quality improvement efforts and improve care for mothers and babies

Created from a Centers for Disease Control, Division of Reproductive Health source

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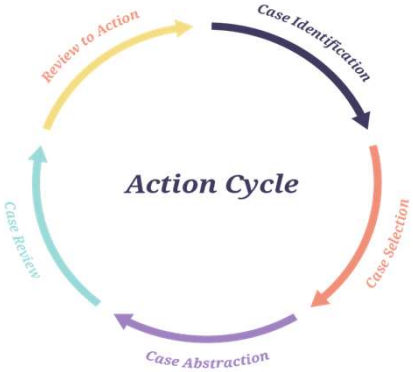
REVIEW to ACTION
WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

- Pregnancy, childbirth, and the year postpartum is a time of transformation for the mother or birthing person, the baby and their family
- Maternal mortality…is a measure that signals the health and well-being of women, children, and families and the investment in and priority of that health and the systems that produce it.
- The work of the New Hampshire MMRC is to **identify** and **review** cases of pregnancy associated death, **determine cause(s)** and **preventability**, and generate **recommendations for action**



https://www.reviewtoaction.org/

New Hampshire MMRC Recommendations

Overdose prevention

- Standardize perinatal education about risk for overdose after pregnancy or any period of abstinence
- Provide naloxone kits and standard education at postpartum discharge for patients with OUD
- Improve treatment access through promotion of 211

Address social determinants of health

- **Screen for social determinants of health**
- **Link patients in medical settings to community services**
- **Enhance outreach to homeless community**

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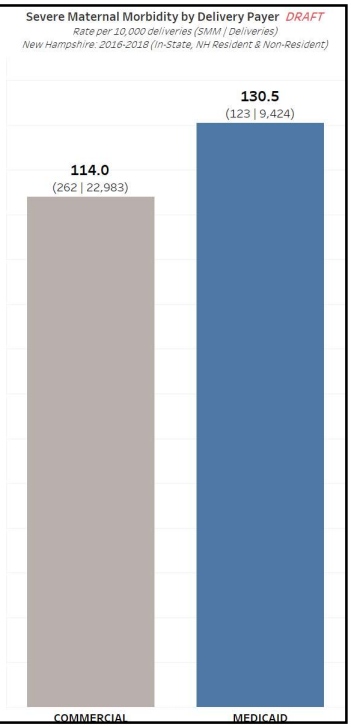
Why are we talking about the Social Determinants of Health (SDOH)?

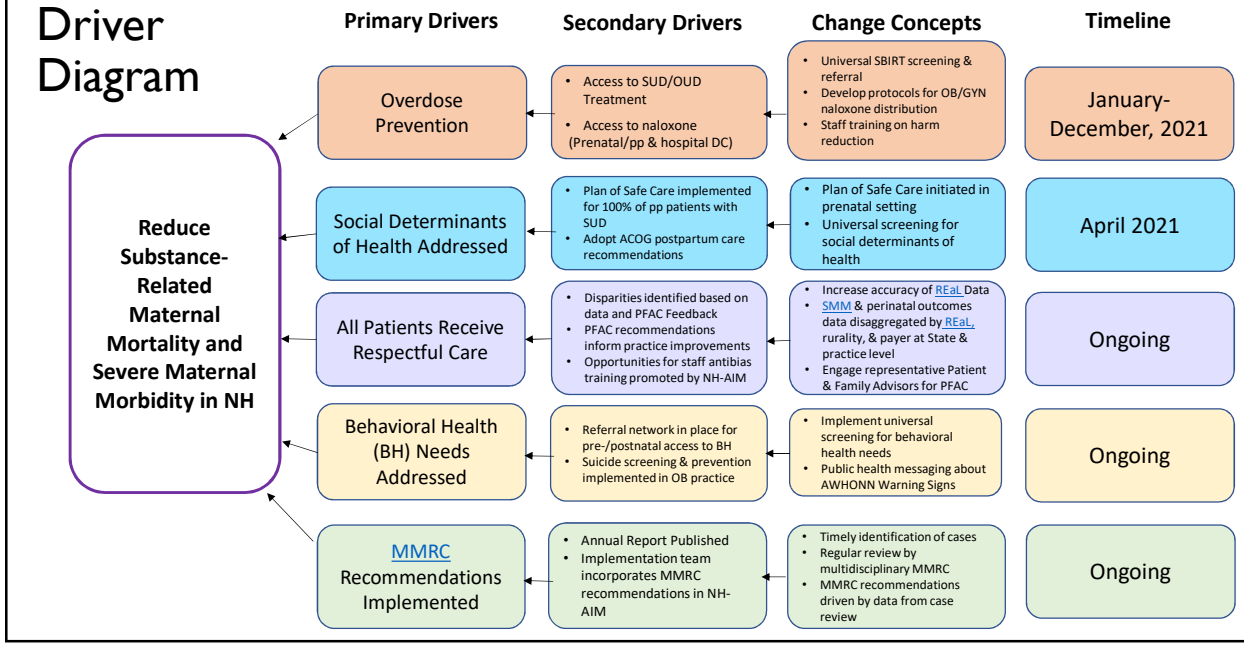
Ellen Stickney, RN, BSN, RNC-OB
Perinatal Nurse Coordinator
Maternal Child Health Section

- Many reasons! For example, the rate of Severe Maternal Morbidity is higher among lower Socioeconomic Status (SES*) persons than higher SES persons in New Hampshire. The SDOH are known to differ across SES strata.
- When considering factors such as how lower SES affects prenatal and postpartum visit status, it becomes evident how the SDOH can lead to different health outcomes.

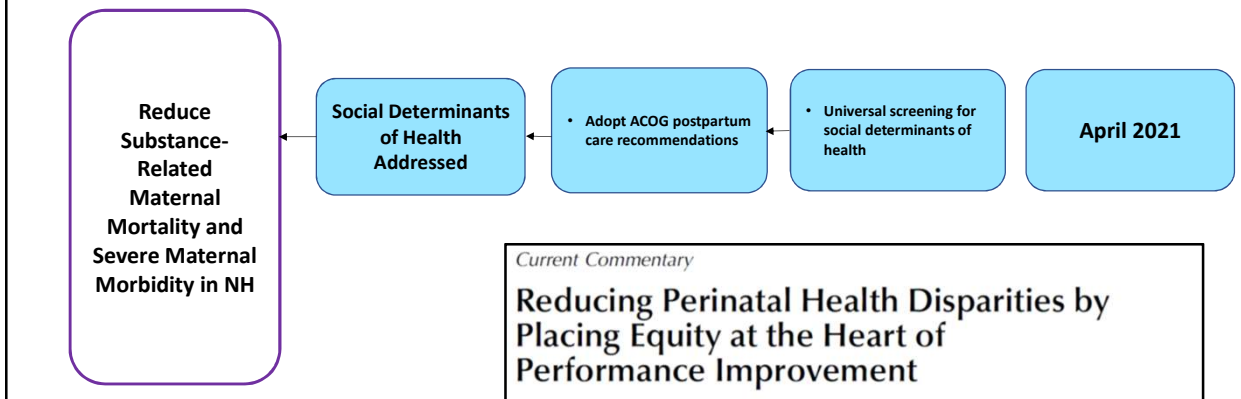
*Defined using Medicaid delivery payer as a proxy for SES since Medicaid is means-tested.



NH-AIM Key Driver Diagram



NH-AIM Key Driver Diagram



Current Commentary

Reducing Perinatal Health Disparities by Placing Equity at the Heart of Performance Improvement

Christina Pardo, MD, MPH, Fouad Atallah, MD, Shifra Mincer, MD, and Howard Minkoff, MD

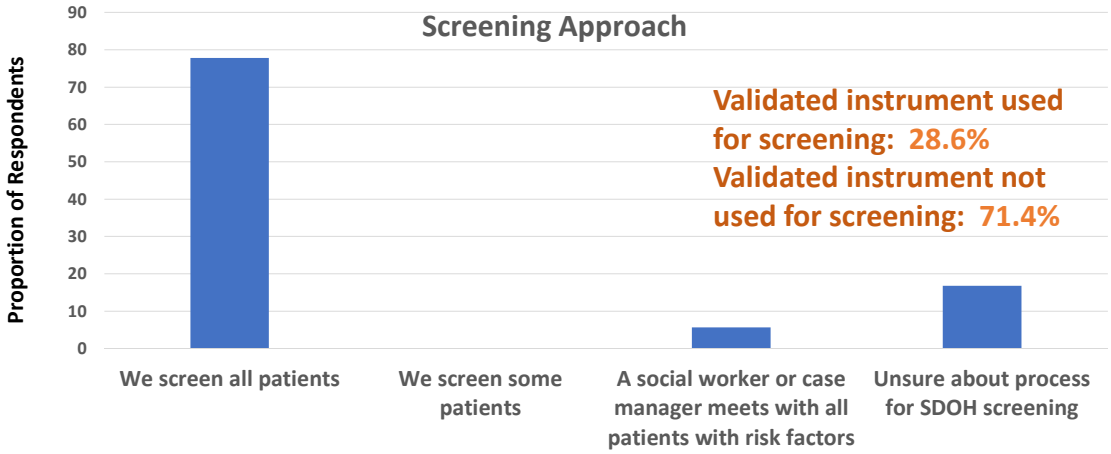
VOL. 137, NO. 3, MARCH 2021 OBSTETRICS & GYNECOLOGY 481

Integrating Social Determinants of Health Screening in Maternity Care: What does best practice look like?

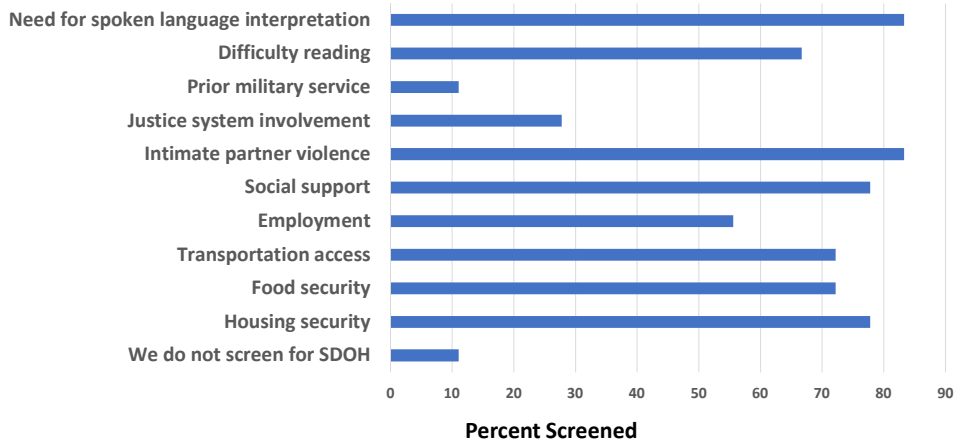
- Screening
  - Universal screening
  - Validated tools
- Providing support/referrals
  - Case management
    - Nursing
    - Community Health Workers/Resource Specialists
    - Social workers
- Documentation
  - For team-based care
  - For reimbursement/sustainability

NH-AIM Baseline Hospital Survey Results

How are New Hampshire's Maternity Care hospitals screening patients for Social Determinants of Health?



Which Social Determinants of Health Are Included in Screening?



Tools for SDOH Screening

Tool	Implementation	Link
AAFP Social Needs Screening Tool	Implementation Toolkit	https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html
PRAPARE	Implementation Toolkit • Webinar trainings • Free EMR templates • Available in 26 languages	https://www.nachc.org/research-and-data/prapare/
CMS Health Related Social Needs Screening Tool	Factsheet	https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
Health Leads Recommended Tool	Implementation Toolkit	https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

What questions are in PRAPARE?

Core	
1. Race*	10. Education
2. Ethnicity*	11. Employment
3. Veteran Status*	12. Material Security
4. Farmworker Status*	13. Social Isolation
5. English Proficiency*	14. Stress
6. Income*	15. Transportation
7. Insurance*	16. Housing Stability
8. Neighborhood*	
9. Housing Status*	

Optional	
1. Incarceration History	3. Domestic Violence
2. Safety	4. Refugee Status

Optional Granular	
1. Employment: How many hours worked per week	3. Insurance: Do you get insurance through your job?
2. Employment: # of jobs worked	4. Social Support: Who is your support network?

* UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

https://www.nachc.org/research-and-data/prapare/

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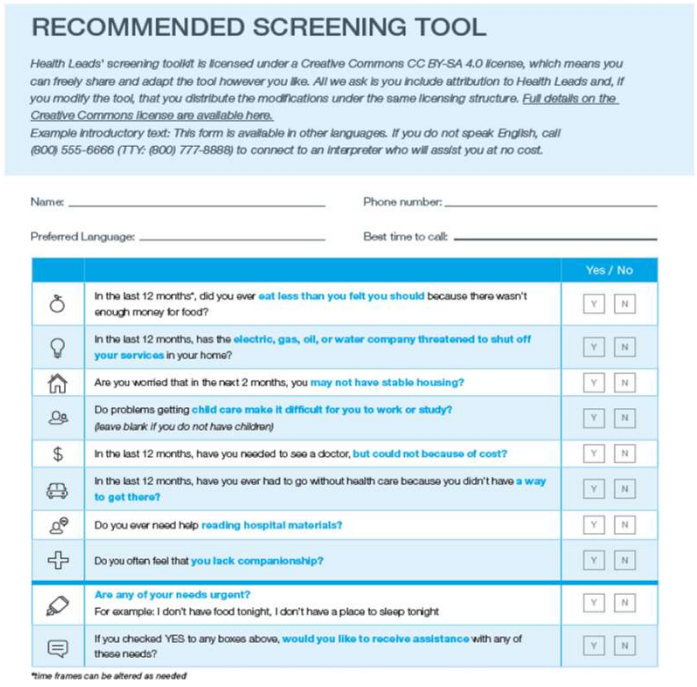
Health Leads Social Needs Screening Tool

- Available in English and Spanish
- Implementation Toolkit: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/



RECOMMENDED SCREENING TOOL

Health Leads' screening toolkit is licensed under a Creative Commons CC BY-SA 4.0 license, which means you can freely share and adapt the tool however you like. All we ask is you include attribution to Health Leads and, if you modify the tool, that you distribute the modifications under the same licensing structure. Full details on the Creative Commons license are available here.

Example introductory text: This form is available in other languages. If you do not speak English, call (800) 555-6666 (TTY: (800) 777-8888) to connect to an interpreter who will assist you at no cost.

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

		Yes / No
	In the last 12 months*, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work or study?** *(leave blank if you do not have children)*	Y N
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Do you often feel that **you lack companionship?**	Y N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N

**time frames can be altered as needed*

Coding and Reimbursement for Addressing SDOH

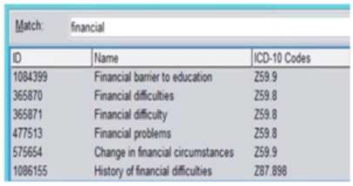
Additional reimbursement is available with 2021 E/M changes

- New Code Selection Criteria emphasize complexity of medical decision making
- "Diagnosis or treatment significantly limited by social determinant of health" added as criteria for Moderate Risk of Complications and/or Morbidity or Mortality of Patient Management (99214)

Documentation must include

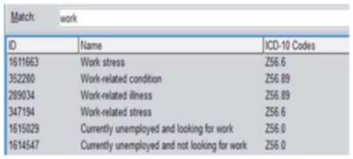
- History: briefly describe problem faced by patient (ex: *"unable to get labs drawn due to transportation issues"*)
- Visit diagnosis (ex: **Lack of Access Transportation** Z91.89)
- Brief description of intervention (ex: **patient met with RN to discuss Medicaid transportation**)

Example Z-Codes



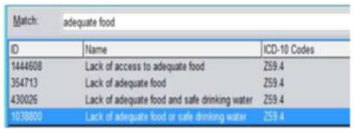
Match: financial

ID	Name	ICD-10 Codes
1084399	Financial barrier to education	Z59.9
365870	Financial difficulties	Z59.8
365871	Financial difficulty	Z59.8
477513	Financial problems	Z59.8
575654	Change in financial circumstances	Z59.9
1086155	History of financial difficulties	Z87.898



Match: work

ID	Name	ICD-10 Codes
1611663	Work stress	Z56.6
352280	Work-related condition	Z56.89
289034	Work-related illness	Z56.89
347194	Work-related stress	Z56.6
1615029	Currently unemployed and looking for work	Z56.0
1614547	Currently unemployed and not looking for work	Z56.0



Match: adequate food

ID	Name	ICD-10 Codes
1444608	Lack of access to adequate food	Z59.4
354713	Lack of adequate food	Z59.4
430026	Lack of adequate food and safe drinking water	Z59.4
1038800	Lack of adequate food or safe drinking water	Z59.4

Match: transportation

ID	Name	ICD-10 Codes
1290787	Assistance needed with transportation	Z74.8
1290786	Assistance with transportation	Z74.8
1037088	Dependent for transportation	Z74.8
424260	Inability to acquire transportation	Z59.8
1578189	Lack of access to transportation	Z91.89

Social Determinants recognized as contributing to level of medical decision making:

- Food insecurity
- Housing instability
- Access to education
- Literacy level
- Discrimination
- Incarceration or other justice involvement
- Access to health care services
- Exposure to violence
- Access to transportation

Integrating SDOH Screening in Maternity Care Practice

Two examples from New Hampshire

Gabi Teed, BSW, CRSW
Amoskeag Health
Manchester, NH

Addressing SDOH at Amoskeag Health

GABI TEED, BSW, CRSW

PERINATAL SUD CARE COORDINATOR

AMOSKEAG HEALTH

Patient Centered Medical Home Model – Integrated Care

Demographics

- 15,000 + Patients
- 65 Languages
- In-house interpreters for 10 languages
- Most insurances accepted and sliding scale option

Services Offered

- Primary Care
- Pediatrics
- OBGYN
- Eye Clinic
- Behavioral Health
- MAT
- Podiatry
- Nutrition
- Case Management
- Family Support Programs
- Early Supports and Services

AMOSKEAG HEALTH

Case/ Care Management

Tools Used

- CCSA – ages 18+
- Family Risk Assessment –ages 0-17
- Verbal inquiry

When

- Assessments conducted at least annually at intake and at time of annual physical exam
- Verbal inquiry conducted by care providers at Patient appointments

Follow-up

- Assessed by CHW who then makes referrals / warm hand-offs made
- Providers and CHW refer to Case Managers if more support needed

AMOSKEAG HEALTH

Comprehensive Core Standardized Assessment (CCSA) Domains

- Demographic
- Medical
- Substance Use (SBIRT)
- Housing
- Family and Support Services
- Education
- Legal
- Depression
- Risk Assessment
- Functional Status
- Pediatric Developmental Screening

AMOSKEAG HEALTH

SDOH Resources

In-House

- Extensive food pantry
- Eye clinic
- Diaper Pantry
- Transportation Assistance
- Medication Assistance
- Language support
- Medicaid Enrollment Coordinators
- Barrier Reduction Funds for PSUD

Community

- Food Pantries
- NH Legal Assistance
- DHHS
- Waypoint
- Easter Seals
- Elliot Hospital
- Recovery Community
- Etc….

AMOSKEAG HEALTH

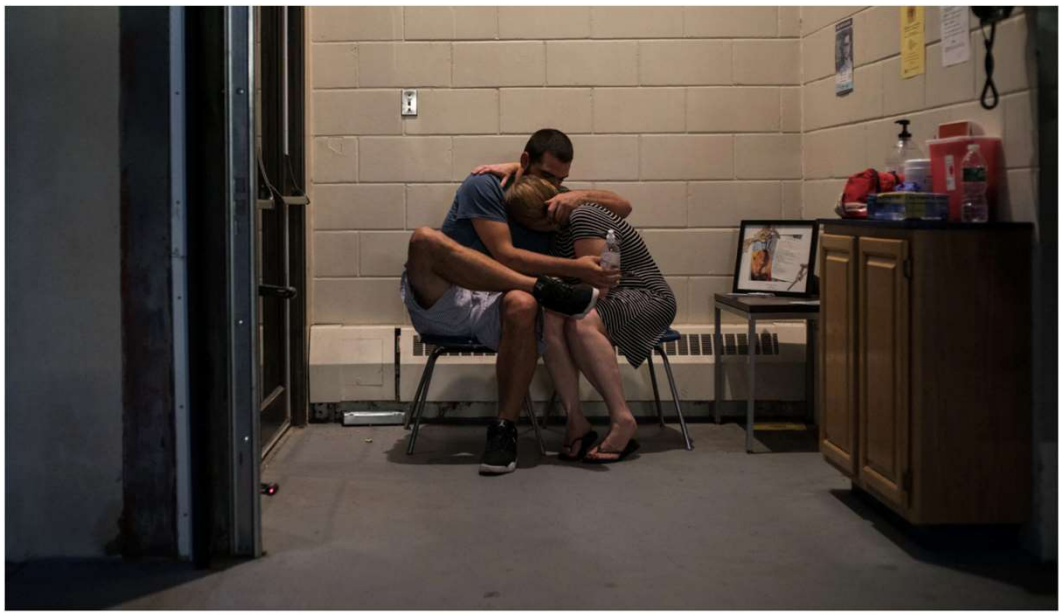
Autumn Versace, CNM, MSN
Cheshire Medical Center
Keene, NH

Partnering for Prevention

Improving Effective Screening and Right Care for Psychosocial Needs in Pregnancy

Background

National guidelines, including those of the US Preventive Services Taskforce (USPSTF) and the American College of Obstetricians and Gynecologists (ACOG), recommend screening pregnant patients for social risk factors including housing, depression, substance use, and exposure to violence. The prevalence of these problems, which confer significant health risk to parents and children, is widespread.



Justin Lerra hugged his girlfriend, Sarah, who was pregnant, as he turned himself in to the Manchester, N.H., fire station to get treatment for his opioid addiction. She had insisted he get treatment or she would


OPPORTUNITY


Saving lives

The Roadmap

SCREENING

SHARED DECISION-MAKING

RIGHT CARE

TEAM ENGAGEMENT

(Green Form)

PRENATAL PSYCHOSOCIAL HEALTH ASSESSMENT

Prenatal psychosocial problems may be associated with unfavorable postpartum outcomes. The questions on this form are suggested ways of inquiring about psychosocial health. Issues of high concern to the woman or caregiver usually indicate a need for additional supports or services. When issues of some concern are identified follow-up and/ or referral should be considered. Please consider the sensitivity of this information before sharing it with other caregivers.

Name:

PRENATAL FACTORS	COMMENTS
MATERNAL FACTORS	
Prenatal care (late onset) (*WA*) • First prenatal visit in third trimester? (check records) • What is the reason that you did not start prenatal care sooner?	
Prenatal education (refusal or quit) (*CA*) • What are your plans for prenatal classes? • What is your reason for not attending/quitting prenatal classes?	
Feelings toward pregnancy after 20 weeks (*CA,WA*) • How did you feel when you first found out you were pregnant? • How do you feel about it now?	
Relationship with parents in childhood (*CA*) • How did you get along with your mother? Your father? • Did you feel loved by your mother? Your father?	
Self esteem (*CA,* WA) • What concerns do you have about becoming/being a mother? • What sort of mother do you think you'll be?	
Histor	

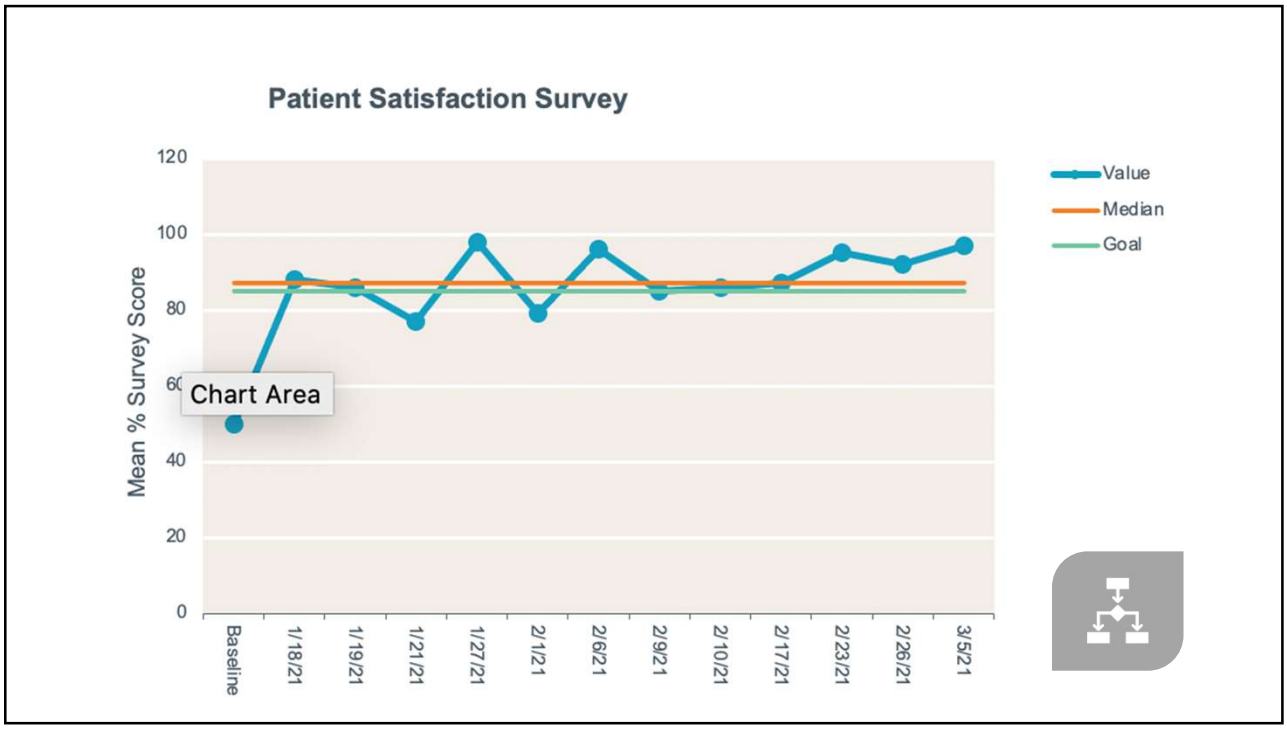
screening

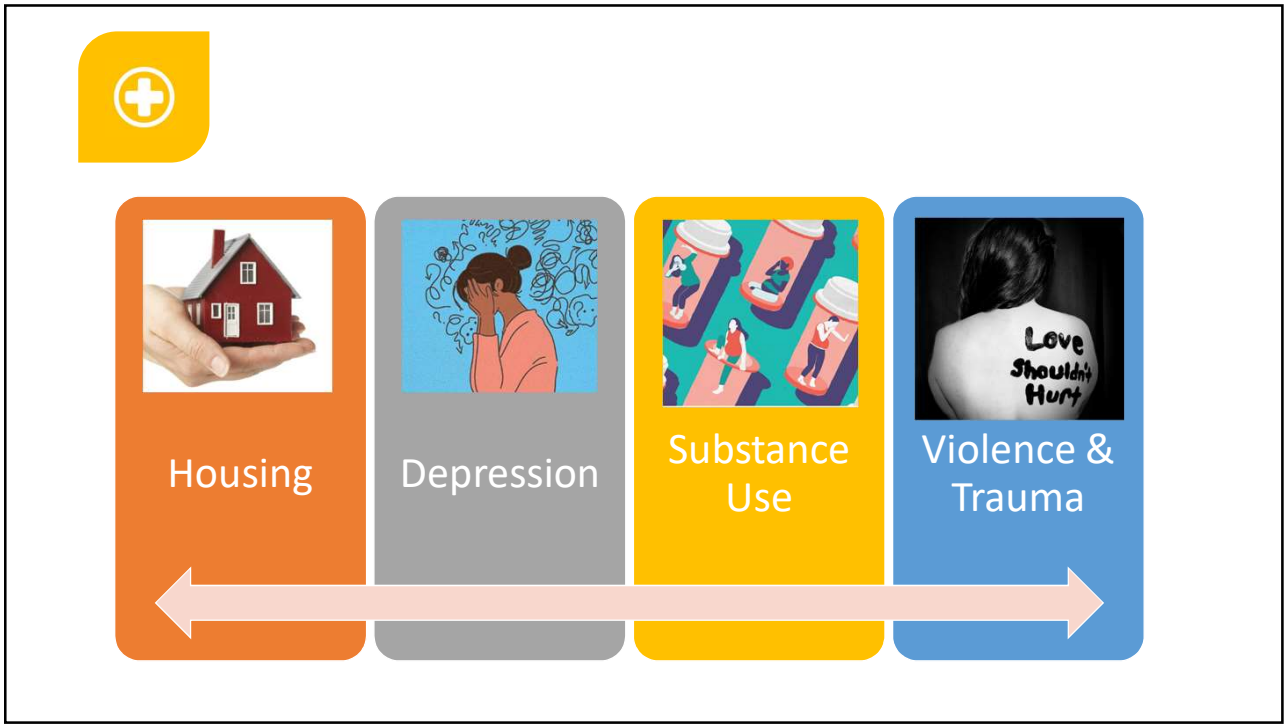
Need Criteria	PDSA 1 N=9		PDSA 2 N= 18		PDSA 3 N=23		PDSA 4 N=28		Total N= 78	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Housing	0	0	2	9	5	24	4	15	11	14
Depression	2	50	13	57	15	71	2	7	32	41
Substance Use	0	0	5	22	1	5	15	56	21	27
Violence	2	50	3	13	0	0	6	22	11	14
Patients With At Least 1 Need Identified	3	33	14	78	16	55	17	61	50	64

Social Support Worksheet

My Options	What is this?	What are some reasons to choose this option?	What are some barriers to this option?	What do I have to do?
Centering Pregnancy	Group-based prenatal care on Zoom.	Connection with other families, information and support.	Not having reliable WiFi.	Tell your provider you want to enroll, attend your groups online.
Healthy Starts Referral	Provides peer and skilled nursing support in your home.	Help for parenting, access to resources, nursing care in your home.	Some people don't want a visitor in their home, but actually HS can visit you virtually, too.	Fill out the referral form and watch for a call from "Home Healthcare, Hospice, Community Services"
Prenatal Wellness Program Referral	Visits with Dr. Hitchings, our health psychologist.	To receive counseling and learn coping strategies.	If you think you can't or won't attend appointments.	Ask your provider to refer you and then take a call with scheduling to see "Dr. Amanda Hitchings."
Monadnock Center for Violence Prevention	A group of advocates who help people in crisis.	They can help if you are experiencing violence, stalking, housing problems, sexual assault, or other problems.	Sometimes people are worried reports will be made to the police if they come forward, but *Advocates* are not required to report domestic violence.	https://mcvprevention.org/ 1-888-511-MCVP You do not need to be in crisis to call, they help everyone.
Mothers in Recovery	Cheshire Medical Center's treatment program for mothers with opioid use disorder.	You can get medication assisted treatment, prenatal care, and recovery care all in one place.	If you are already established with another program and don't want to transfer. If office-based treatment isn't right for you.	Talk to us! We'll tell you more.
The Doorway	Entry point for help with substance use disorder.	Help is available 24/7 and there is a Doorway location right in Keene (and others throughout the state).	If you are already established with another program.	Call "211"
Childbirth Classes	Classes for birth, breastfeeding, and baby care.	Information, discussion, meeting other families.	Cost, but scholarships are available—ask us. No WiFi access (classes are virtual.)	https://www.cheshiremed.org/pregnancy-birth/childbirth-education 603-354-5454 ext. 8388
Southwest Community Services	Help with housing, food, heat, transportation, job assistance.	One stop shop for help with local resources.	Need to have a phone that accepts calls, and phone service.	603.352.7512 https://www.scshelps.org/

Circle Your Choices							
Centering Pregnancy	Not Interested	1	2	3	4	5	Very Interested
Healthy Starts Referral	Not Interested	1	2	3	4	5	Very Interested
Prenatal Wellness Program	Not Interested	1	2	3	4	5	Very Interested
Monadnock Center for Violence Prevention	Not Interested	1	2	3	4	5	Very Interested
Mothers in Recovery	Not Interested	1	2	3	4	5	Very Interested
The Doorway	Not Interested	1	2	3	4	5	Very Interested
Childbirth Classes	Not Interested	1	2	3	4	5	Very Interested
Southwest Community Services	Not Interested	1	2	3	4	5	Very Interested
I have my own plan. Please Describe:							
My goal for this pregnancy:							

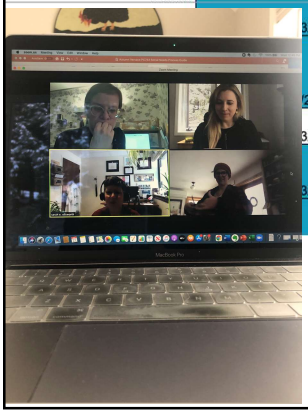

Patient Satisfaction Survey
Mean % Survey Score
120
100
80
60
40
20
0
Chart Area
Baseline
1/18/21
1/19/21
1/21/21
1/27/21
2/1/21
2/6/21
2/9/21
2/10/21
2/17/21
2/23/21
2/26/21
3/5/21
Value
Median
Goal


Housing
Depression
Substance Use
Violence & Trauma
Love Shouldn't Hurt

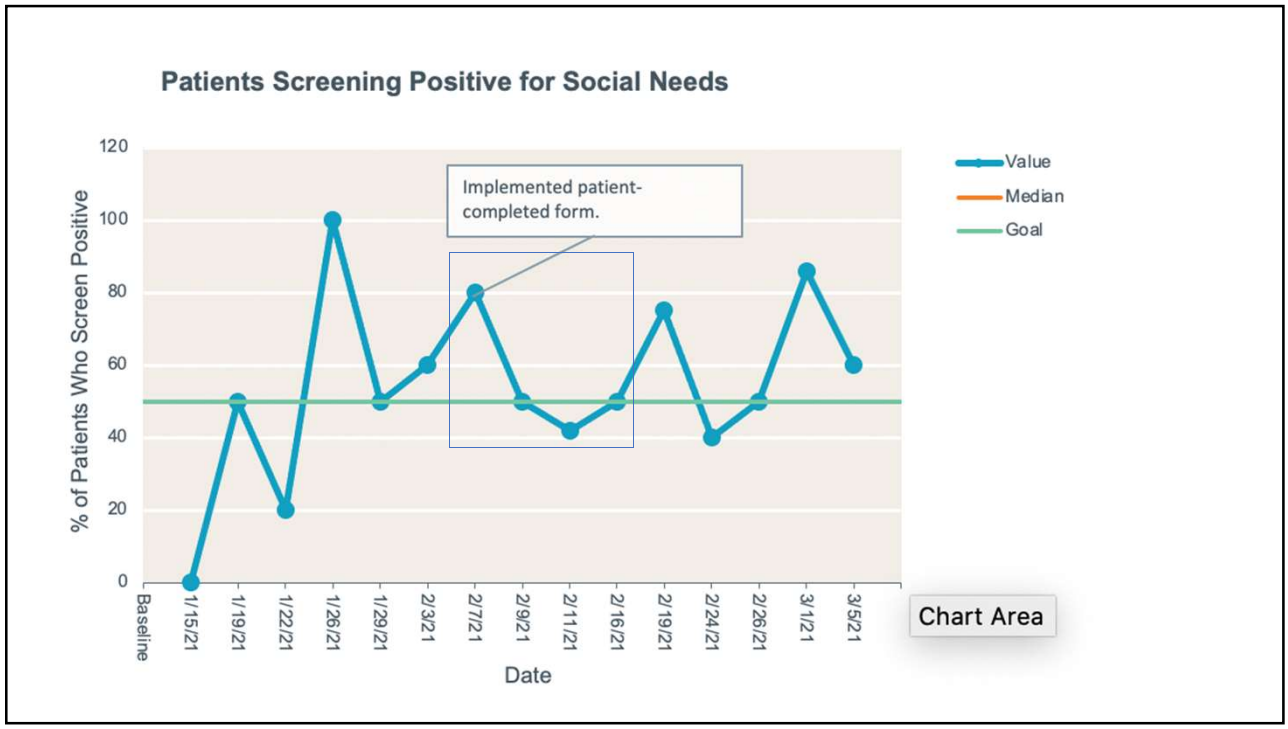

Right Care Received
Mean % Right Care Score
120
100
80
60
40
20
0
Baseline
1/22/21
1/26/21
1/29/21
2/3/21
2/7/21
2/9/21
2/10/21
2/15/21
2/19/21
2/24/21
2/26/21
3/1/21
3/5/21
Date
Checklist implemented.
Value
Median
Goal
Right Care:
-Need addressed
-Referred appropriately
-Follow up scheduled

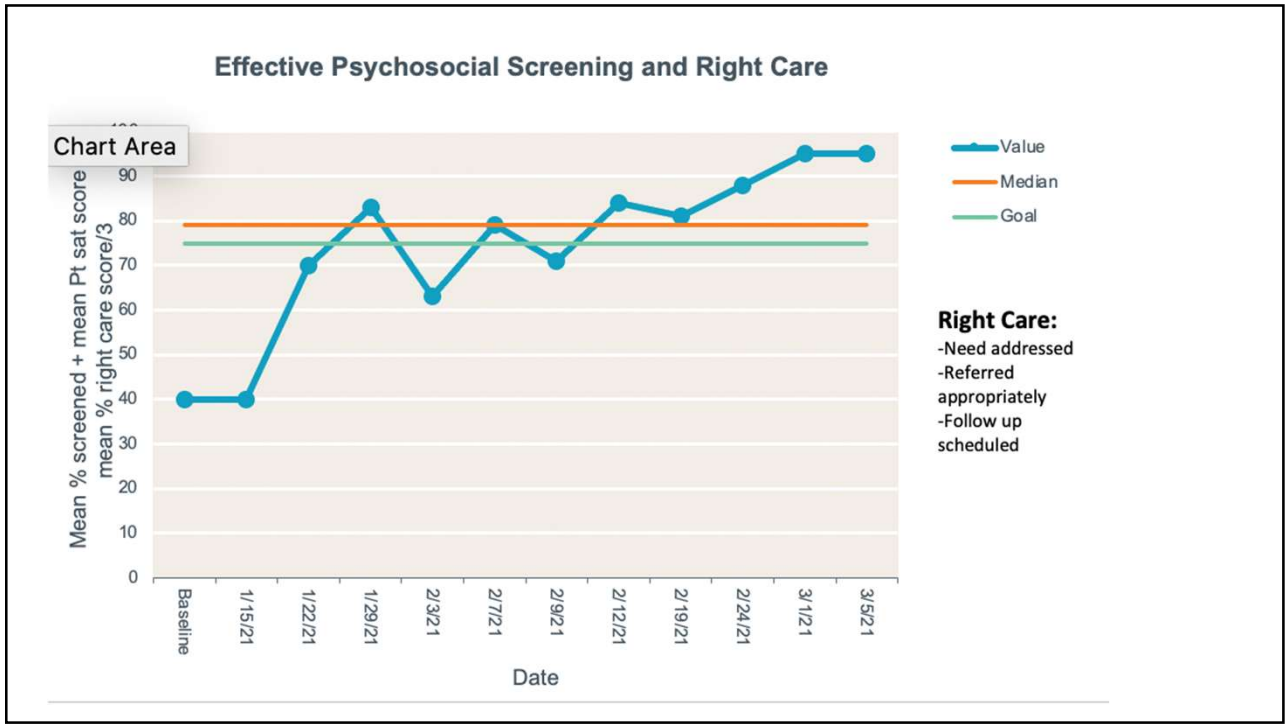

Team Engagement

Dates						Encounter
Plan	Actual	Communication Type	Objective of Communication	Medium	Frequency	Planned
Cycle 1						
12/29/20	12/29/20	Kickoff Meeting	Describe project and secure buy-in through description of the problem.	Zoom	Once	12: CMC Clinic personnel, patient rep, and community rep named in the team plan.
1/12/20		Implementation Start Meeting	Debut the Interview and SDM packets and tracking process. Discuss right care bundles and patient surveys.	Zoom	Once	12: CMC Clinic personnel, patient rep, and community rep named in the team plan.
1/11/20		First Weekly Email	Updates, Data Sharing, Goals for the Cycle	Email	Weekly	To all team members with read receipts
1/18/20		Provider Zoom Huddle	Process clarification, feedback on implementation during the pilot.	Zoom	Once	6: Clinical staff with direct patient care responsibilities.
	3/2/21	All Team Meeting	Report out of PDSA 3 data and planning for future cycles.	WebEx.	q2w	12: CMC Clinic personnel, patient rep, and community rep named in the team plan.
	/23/21	TDI SDM Email	Educate providers about TDI's connection with shared decision-making in order to increase engagement.	Email	Once	All providers
	3/3/21	Provider Zoom Huddle	Process clarification, feedback on implementation during the pilot.	Zoom	Once	6: Clinical staff with direct patient care responsibilities.
	3/5/21	Meeting with lead MA	Talking about RC checklist for positive PHQ2/9 screening (improving process for Mas.	In Person	Once	Impromptu
		Individual debriefs with	Defbrief process, thoughts, to inform			Sarah, Ryan, Jesse (need to meet with Melody and



Team Survey Likert Scores	PDSA 1 N=4			PDSA 2 N=4			PDSA 3 N=8			PDSA 4 N= 10			Total N= 26		
	Mean	*Median*	*Range*	*Mean*	*Median*	*Range*	*Mean*	*Median*	*Range*	*Mean*	*Median*	*Range*	*Mean*	*Median*	*Range*
How would you describe our team efficacy?	3.75	3.5	3-5	3.75	4	3-4	3.9	4	3-4	3.4	3.5	2-4	3.7	3.5	2-5
Which statement best describes our staff's understanding of their roles and responsibilities?	4.25	4	4-5	4	3	3-5	4	4	3-5	3.4	4	2-4	3.9	4	2-5
How would you describe the way our teamcommunicates clinical information to our patients?	4	4	3-5	2.8	2.5	2-5	3	3.5	1-4	3.5	4	2-4	3.3	3.5	1-5
This project did not increase my workload.	3.5	3.5	2-5	2	2.5	2-3	4	4	1-5	3.3	3	1-5	3.2	3.25	1-5
How much do you know about community resources for housing?	2	2	2	2.2	2	2-5	4	3.5	2-5	2.8	3	1-5	2.75	2.5	1-5
How much do you know about community resources for intimate partner violence?	2.75	2.5	2-4	3.2	4	3-5	4	4	2-5	3.2	3.5	1-5	3.3	3.75	1-5
How much do you know about community resources for substance use?	3	3	2-4	4.25	4	4-5	4	4	2-4	3.2	3.5	1-5	3.6	3.75	1-5
How much do you know about community resources for depression?	2.75	2.5	2-4	4.5	4.5	4-5	4	4	2-5	3.6	4	1-5	3.7	4	1-5


Patients Screening Positive for Social Needs
% of Patients Who Screen Positive
120
100
80
60
40
20
0
Implemented patient-completed form.
Value
Median
Goal
Baseline
1/15/21
1/19/21
1/22/21
1/26/21
1/29/21
2/3/21
2/7/21
2/9/21
2/11/21
2/16/21
2/19/21
2/24/21
2/26/21
3/1/21
3/5/21
Date
Chart Area


Effective Psychosocial Screening and Right Care
Chart Area
Mean % screened + mean Pt sat score
mean % right care score/3
90
80
70
60
50
40
30
20
10
0
Value
Median
Goal
Right Care:
-Need addressed
-Referred appropriately
-Follow up scheduled
Baseline
1/15/21
1/22/21
1/29/21
2/3/21
2/7/21
2/9/21
2/12/21
2/19/21
2/24/21
3/1/21
3/5/21
Date

Sustain Plan

Right Now

- Continue social needs screening by confidential provider interview.
- Continue with right care bundles
- Continue SDM
- Continue to strengthen community partnerships

Near Future

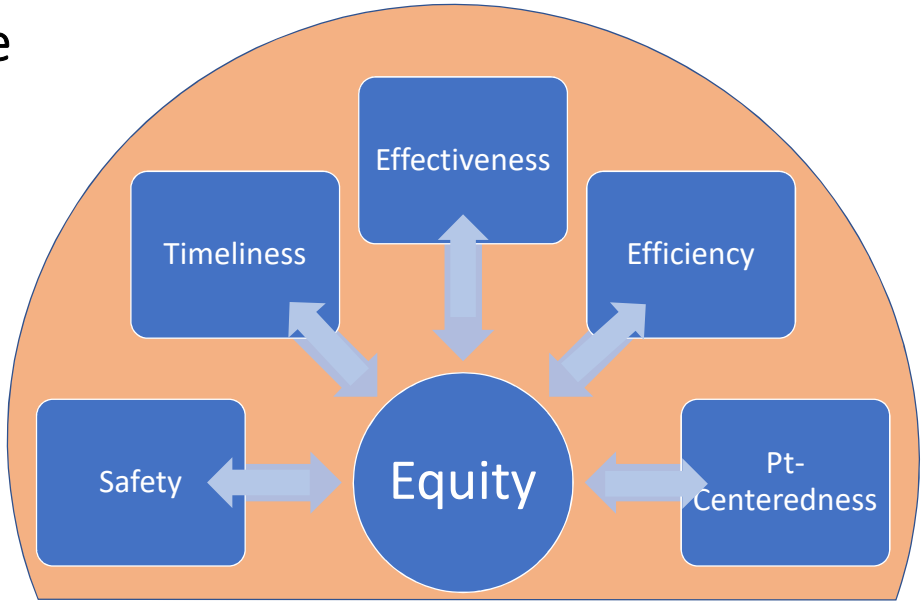
- Move SDM to an electronic format
- Increase prenatal care coordination (maintain a case log)
- Reexamine prenatal intake process

"Health equity is achieved when every person has the opportunity to "attain full health potential" and **no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.**"

- How will we know what barriers our patients face unless we ask?

https://www.cdc.gov/chronicdisease/healthequity/index.htm

Health Care Quality



Courtesy of Trinidad Tellez, MD, with permission

Current Commentary

Reducing Perinatal Health Disparities by Placing Equity at the Heart of Performance Improvement

Christina Pardo, MD, MPH, Fouad Atallah, MD, Shifra Mincer, MD, and Howard Minkoff, MD

Obstetrics and Gynecology 2021; 137; 3: 481-485

"Equity will never be fully addressed until performance-improvement committees, the designated performance watchdogs in departments of obstetrics and gynecology, accept equity as a key component of their charge…"

"No organization or department can be credited with attaining high quality if any particular group is left behind, and if all groups are recipients of equally substandard care there is no quality"

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Upcoming:

NH AIM/ERASE Maternal Mortality Webinar
July 15, 2021 (12 – 1PM)

Integrated Practice

To Receive CME/CNE Credit for today's session, Text 603-346-4334
Enter Activity Code: drPy *(Good for this Live Session Only)*
Need help? **clpd.support@hitchcock.org**
Signing in on-line? **http://www.d-h.org/clpd-account**

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

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CHI Resources:

This is available through the POSC website it was compiled so that practices would have a resource:
https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/
Check out the Pregnant and Parenting Services and Supports *link* and *map.*

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

SAVE THE DATE
June 10, 2021
NNEPQIN Virtual Spring Meeting

Let's stay in touch….

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