Understanding the Current Social Needs of Health Center Patients

September 20, 2022

National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

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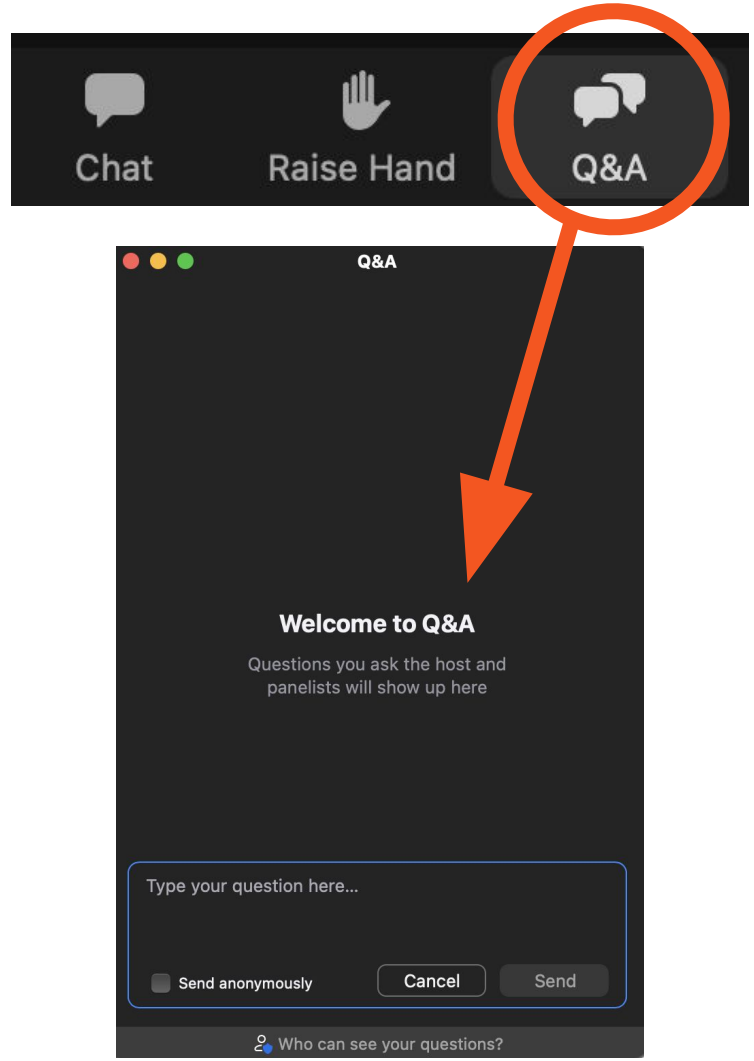
Housekeeping

- Attendees are muted throughout the webinar.
- Type questions into Questions & Answers pane.
- To activate captions, select “Live Transcript” and “Show Subtitle.”
- This webinar will be recorded and shared at medical-legalpartnership.org/resources/
- Send a direct message to Katherine Stinton (NCMLP) for help



Audience Icebreaker

When you log in, take a moment to type the following in the Zoom Chat:

Trivia: The nation's first community health centers were launched as a small demonstration program as part of the President _____'s Office of Economic Opportunity.

- Kennedy
- Johnson
- Nixon
- Clinton

Hint: The year was 1965.

Tell us about you. What type of organization do you represent?

- Health Center (or Look-Alike)
- Other Health Care (e.g., hospital, palliative care clinic, nursing home, etc.)
- Legal Services (or Law School)
- Research Institution
- Public Policy
- Other (please specify)

The Health Center MLP Toolkit

Webinar Series:

- **Understanding the Current Social Needs of Health Center Patients**
- Screening, Referral, and Service Delivery Workflows
- Workforce Development | Training Staff to Identify the Health-Harming Legal Needs of Patients
- Patients-to-Policy Initiatives
- Evaluation and Sustainability for MLPs

Access the toolkit:
medical-legalpartnership.org/mlp-resources/health-center-toolkit/

What SDOH problems do we want to address?

From the Health Center MLP Toolkit: “9 Conversations to Help Your Health Center Lay a Strong Foundation for a Medical-Legal Partnership”

Three approaches

All patients, specific social need

Example

The most common unresolved social needs among the health center's patients pertain to housing*, so MLP resources are focused there. Any clinician or staff member can refer any patient to the MLP lawyer for assistance with evictions, housing conditions, housing subsidies, etc. The health center may or may not choose to expand to other issues in the future.

**This could also be access to public benefits, access to educational supports, etc.*

Specific patient population, all social needs

Example

The health center's needs assessment reveals that pregnant people* would benefit most from legal services. Any clinician or staff member can refer any pregnant person to the MLP lawyer for any identified social need. The health center may or may not choose to expand to other groups in the future.

**This could also be children with asthma, individuals experiencing homelessness, people who use behavioral health services, people with substance use disorders, socially vulnerable older adults, people with diabetes, transgender individuals, etc.*

All patients, all social needs

Example

Any clinician or staff member can refer any health center patient to the MLP lawyer for any identified social need.

Objectives

Help staff of health centers and medical-legal partnerships better understand:

1) The current data on social needs of health centers patients shifted during the pandemic
2) Upcoming challenges that health centers and MLPs can partner to address
3) How PRAPARE has been leveraged as a powerful tool to collect, understand, and address the health-related social needs of health center patient populations

Today's Panelists & Agenda

BETHANY HAMILTON

Co-Director

National Center for Medical-Legal Partnership

Welcome / Why Are We Here

BRAD CORALLO

Senior Policy Analyst for Program on Medicaid and the Uninsured

KFF

KFF's 2021 National Survey of Community Health Centers

ROSY CHANG WEIR

Director of Research

Association of Asian Pacific Community Health Organizations

PRAPARE and the SDOH Findings

Brad Corallo

KFF

Health Center Patients' Shifting Needs During the COVID-19 Pandemic

Bradley Corallo
bradleyc@kff.org | @BradCorallo

September 20, 2022

KFF

Filling the need for trusted information on national health issues.

Figure 12

2021 National Survey of Community Health Centers

- Conducted by KFF and the Geiger Gibson Program in Community Health Policy at the George Washington University, with support from the RCHN Community Health Foundation

- Purpose:
  - Broad assessment of pandemic's impact on health centers and their patients
  - Monitor other ongoing policy issues, such as substance use disorder treatments and 340B

- Responses:
  - Survey was fielded from September to December 2021
  - Questionnaire sent to all federally-funded health center CEOs in the 50 states and DC
  - 27% response rate (357 complete responses out of 1,342 eligible health centers)

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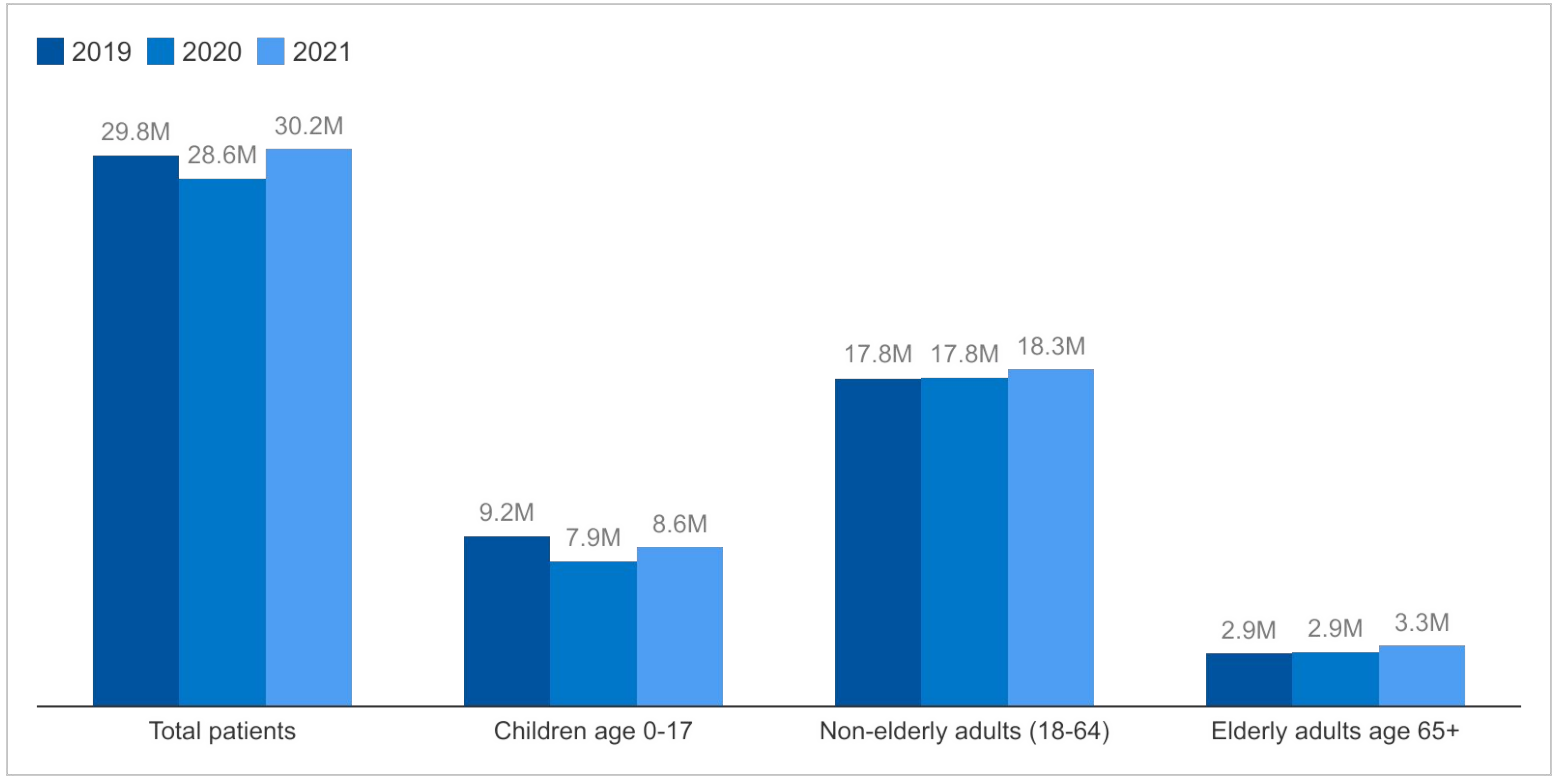
Figure 13

The total number of health center patients dropped in 2020 from the previous year but rebounded in 2021

- However, not all demographic groups have rebounded to pre-pandemic levels
- Patient groups that have not seen a full "rebound" in patient counts *(2019 to 2021 % change)*:
  - Children *(-6%)*
  - People experiencing homelessness *(-11%)*
  - Agricultural workers *(-2%)*
  - Veterans *(-2%)*

Number of patients at federally-funded health centers annually



NOTE: M = Millions. Baseline (2019) patient counts for demographic groups described above are 9.2 million for children, 1.46 million for people experiencing homelessness, 1.03 million agricultural workers, and 399,000 veterans.

SOURCE: Uniform Data System. Bureau of Primary Health Care, HRSA, DHHS. Tables 3A and 4.

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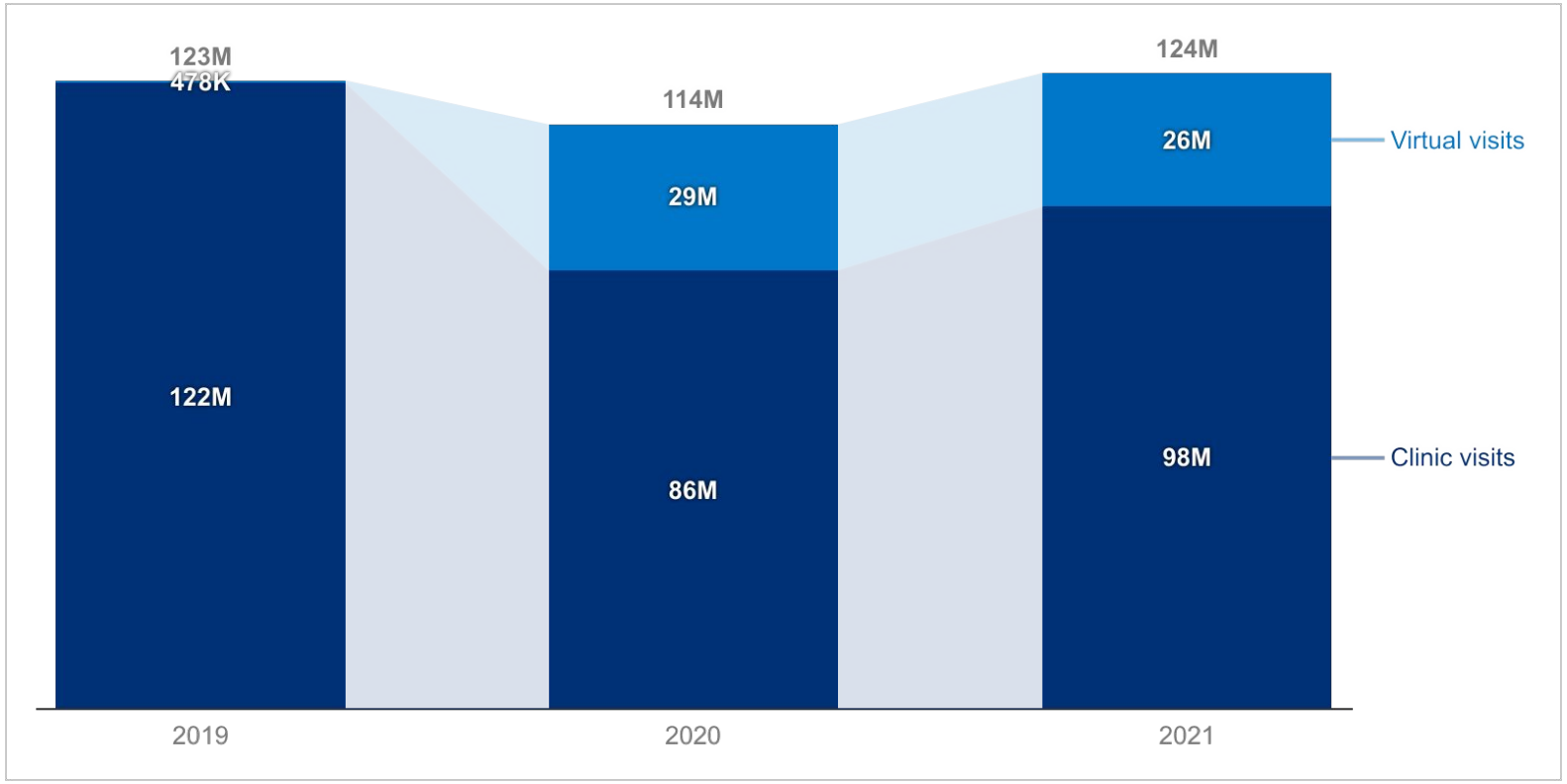
Figure 14

Telehealth became much more common during the pandemic

- <1% of visits were virtual in 2019
- 25% of visits were virtual in 2020
- 21% of visits were virtual in 2021

- In 2019, 43% of health centers utilized telehealth
- By 2021, 99% of health centers utilized telehealth

Total visits to federally-funded health centers, 2019-2021



NOTES: M = Millions; K = thousands.
SOURCE: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

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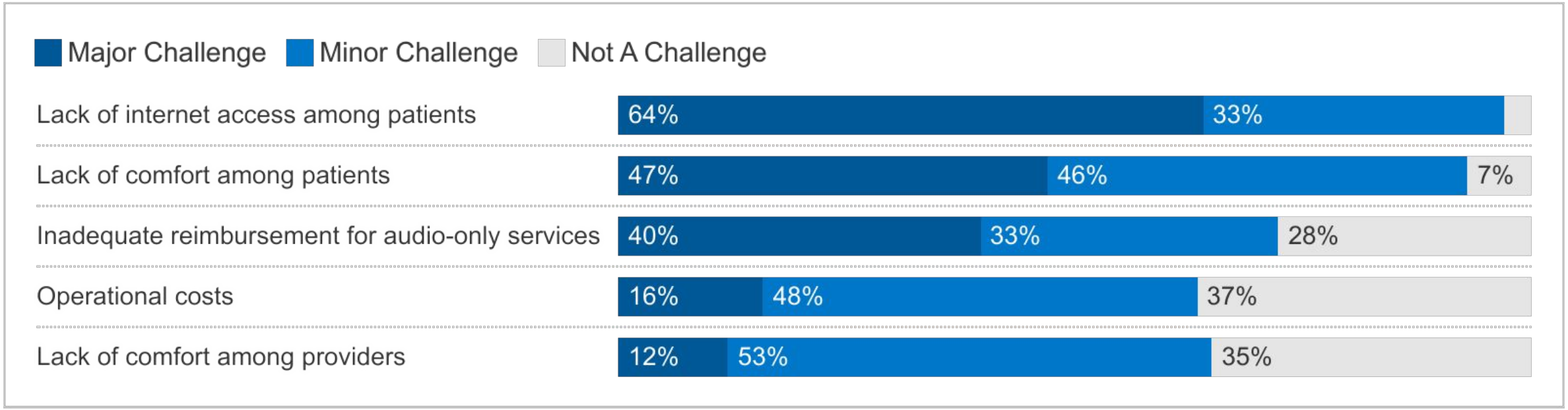
Figure 15

Health centers reported unique challenges providing telehealth

Is the following currently a major challenge, minor challenge, or not a challenge in providing telehealth services?



SOURCE: KFF and Geiger Gibson/RCHN Community Health Foundation Survey of Community Health Centers in the U.S., 2021.

Figure 16

Health centers began providing new COVID-19-related services during a period of great uncertainty

- Health centers were seen as key partners for enabling a more equitable pandemic response

- Health centers provided:
  - 20+ million COVID-19 **tests** throughout the pandemic (cumulative)
  - 21+ million COVID-19 **vaccinations** throughout the pandemic (cumulative)
  - 31% of health centers distribute **oral antiviral medication** (as of August 2022)
  - 8% of health centers directly provide **monoclonal antibody therapy**, 56% refer fort treatment (as of August 2022)
  - Many participate in federal programs for **distributing free N95 masks and at-home rapid tests**

SOURCE: Health Center COVID-19 Survey, Bureau of Primary Health Care, HRSA, DHHS.

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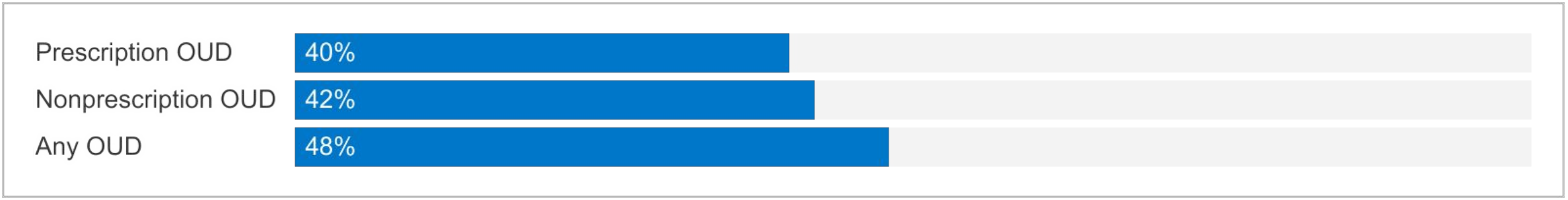
Figure 17

Health centers reported increases in patients experiencing opioid use disorder

Compared to before the pandemic, has your health center seen an increase in the patients with the following type of opioid use disorder (OUD)?



Among health centers that provide medication-assisted treatment (MAT) for OUD, 61% said that they have the capacity to treat all patients seeking MAT for OUD, an increase from 53% in 2019.*

NOTE: * Health centers providing MAT include those providing MAT medication, therapy, or both. In total, 71% of health centers surveyed provided MAT in 2021 compared to 64% in 2019 (a statistically significant increase).

SOURCE: KFF and Geiger Gibson/RCHN Community Health Foundation Survey of Community Health Centers in the U.S., 2019 & 2021.

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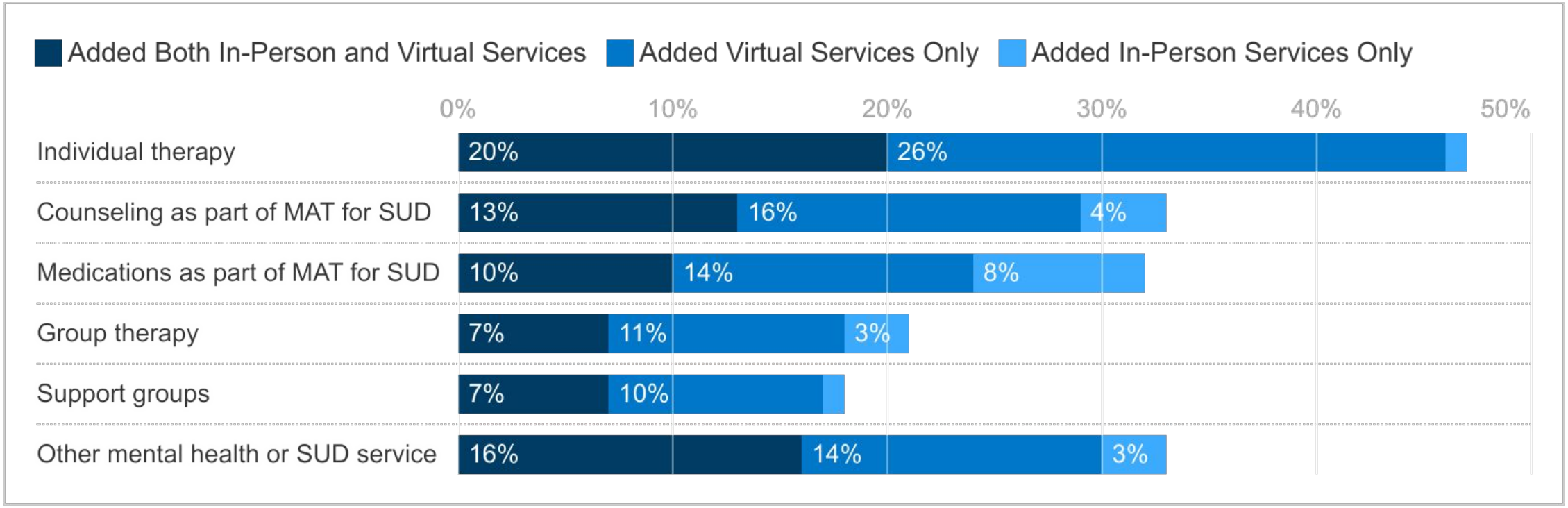
Figure 18

Health centers expanded availability of mental health and substance use disorder (SUD) services

Has your health center newly offered any of these services in-person, virtually, or not at all since before the pandemic?



NOTE: MAT = Medication-assisted treatment. SUD = Substance use disorder.

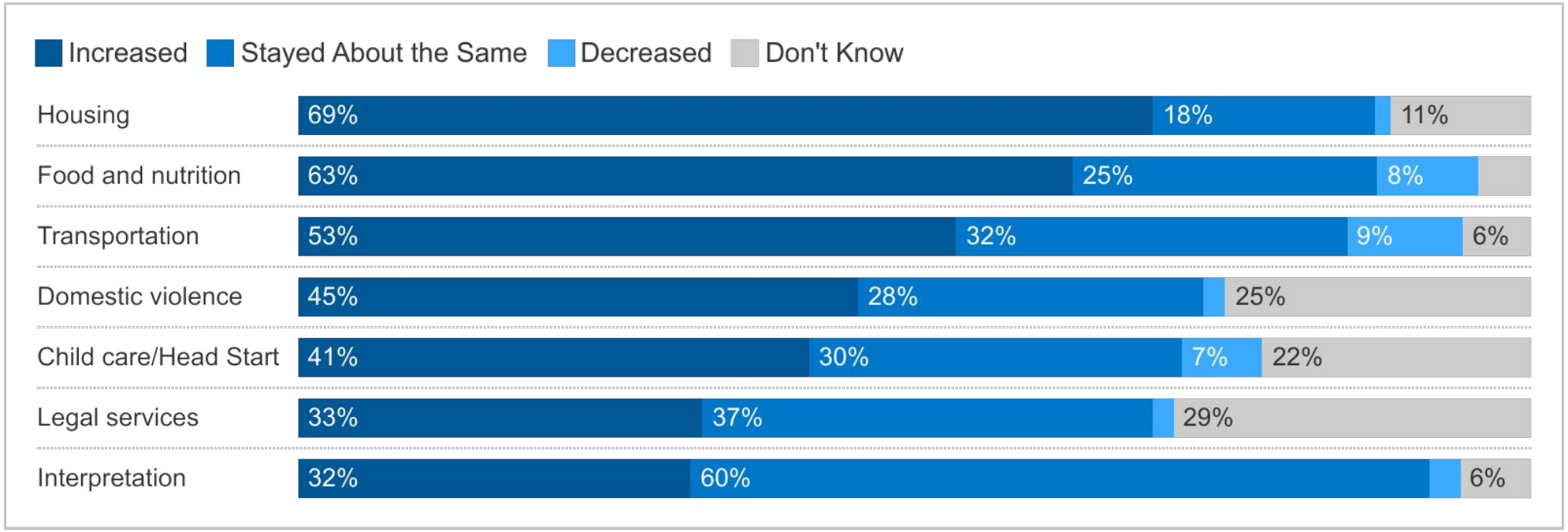
SOURCE: KFF and Geiger Gibson/RCHN Community Health Foundation Survey of Community Health Centers in the U.S., 2021.

KFF

Figure 19

Health centers reported an increase in the number of patients seeking social and supportive services during the pandemic

Compared to before the pandemic, has your health center seen a change in the number of patients currently seeking the following services?



NOTE: N/A responses were not counted in these calculations. "Housing" services include housing placement and support paying utilities.
SOURCE: KFF and Geiger Gibson/RCHN Community Health Foundation Survey of Community Health Centers in the U.S., 2021.

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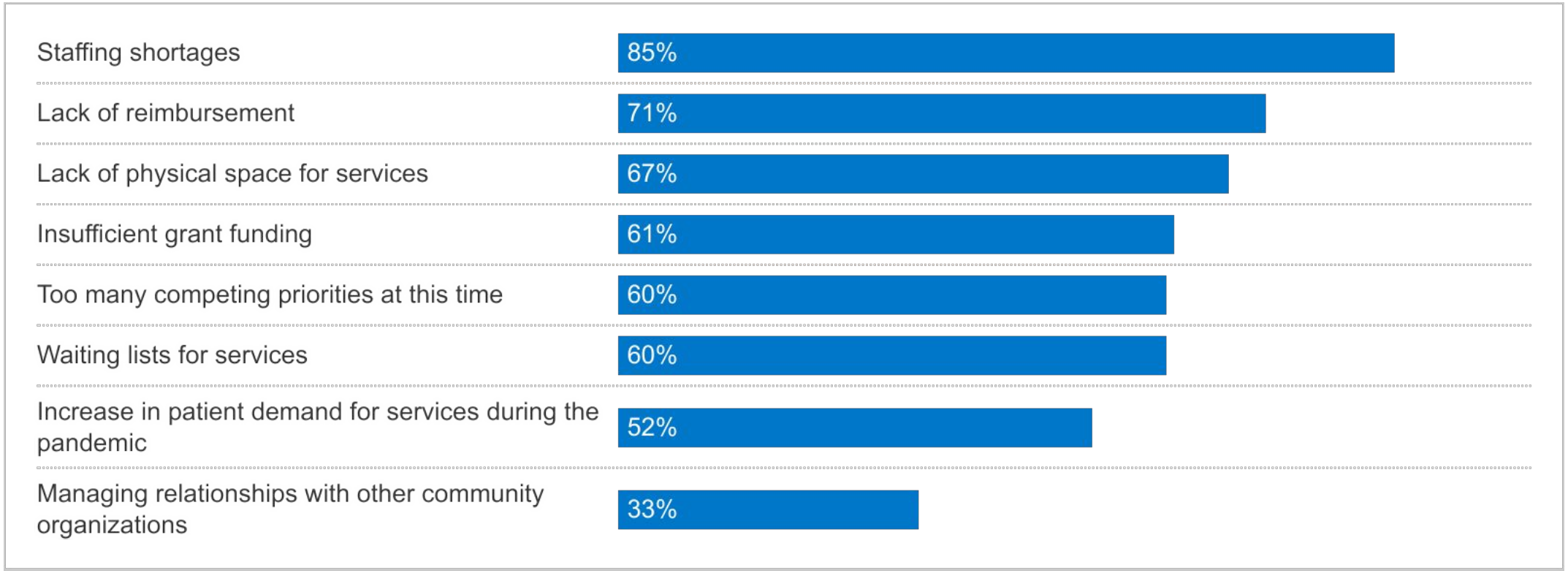
Figure 20

Staffing, reimbursement, and physical space were the most cited challenges for providing enabling services

*What challenges is your health center currently facing in providing **enabling services?***



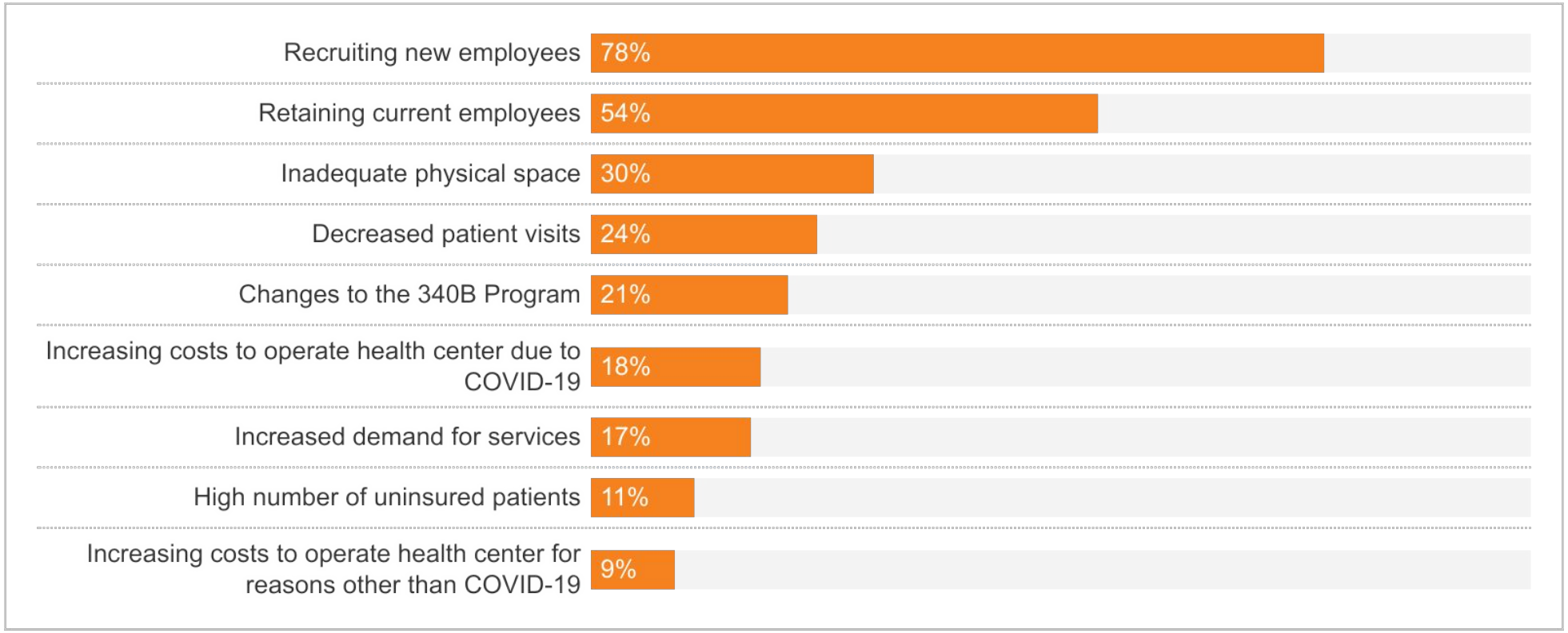
NOTE: Figure does not show 5% of respondents that selected "Other challenges" and 1% of respondents that selected "None of the above, we do not face any challenges providing SUD services." Insufficient grant funding includes the complexity of managing multiple grants.

SOURCE: KFF and Geiger Gibson/RCHN Community Health Foundation Survey of Community Health Centers in the U.S., 2021.

Figure 21

Workforce issues were most cited challenge for health centers overall

*What are the current top three challenges for your health center **overall?***



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SOURCE: KFF and Geiger Gibson/RCHN Community Health Foundation Survey of Community Health Centers in the U.S., 2021.

Health Centers' Plans for Unwinding the Continuous Enrollment Requirement Medicaid

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Figure 23

The Medicaid continuous enrollment requirement has led to a marked increase in Medicaid enrollment

- The continuous enrollment requirement was included in the Families First Coronavirus Relief Act of 2020
- Under the requirement, states generally cannot disenroll anyone from Medicaid coverage for the duration of the public health emergency
  - In return, states receive a temporary increase in their federal match rates for Medicaid spending
- The current PHE runs through mid-October but may be extended for another 90 days
- Medicaid enrollment has reached record highs (89 million people as of May 2022) and expected to continue growing until the end of the PHE

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Figure 24

When the continuous enrollment requirement ends, millions could lose Medicaid coverage

- At the end of the PHE, states will have up 14 months to complete redeterminations for all Medicaid enrollees, although some states may take less time
- Many people will lose Medicaid coverage because they are no longer eligible.
  - E.g., they have a new job with higher income
- Some will lose Medicaid coverage for procedural reasons despite still being eligible.
  - E.g., not responding to documentation requests
- Enrollees may need assistance understanding and responding to documentation requests, notices of termination, and applying for other coverage
- In 2021, 14.5 million health center patients (48%) were enrolled in Medicaid

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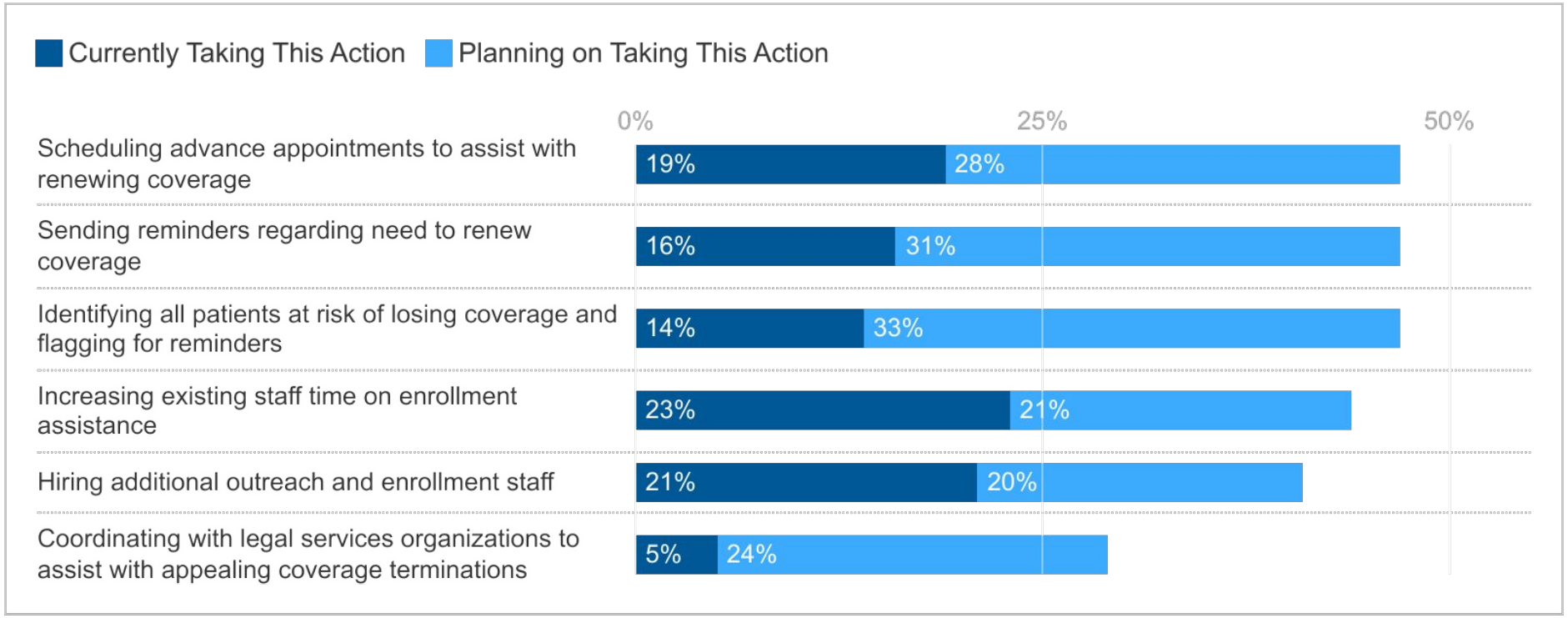
Figure 25

Many health centers have already started preparing for the end of the continuous enrollment requirement

Is your health center currently taking or planning to take any of the following actions to prepare for the unwinding of the continuous enrollment requirement?



NOTE: Figure does not show 2% of health centers currently taking "Other" actions and 5% planning "Other" actions.
SOURCE: KFF and Geiger Gibson/RCHN Community Health Foundation Survey of Community Health Centers in the U.S., 2021

KFF

Figure 26

Looking ahead…

- Total patients and visits are expected to continue increasing in 2020
- Some patients may still prefer to telehealth over in-person visits going forward
- Health centers will likely continue to be an important source of mental health and substance use disorder services
- Ongoing economic conditions in the wake of the pandemic could impact patient demand for social and supportive services
- In the months following the end of the public health emergency, many Medicaid-enrolled health center patients will undergo redeterminations
  - Many will need assistance with redeterminations and/or applying for other coverage
  - Health centers may see an increase in the number of uninsured patients

KFF

Thank you.

QUESTIONS

National Center for Medical Legal Partnership

AT THE GEORGE WASHINGTON UNIVERSITY

Rosy Chang Weir

AAPCHO

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Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Understanding the Value of SDOH Data – PRAPARE® Data Findings

September 2022

Rosy Chang Weir, PhD
rcweir@aapcho.org
Director of Research
Association of Asian Pacific Community Health Organizations

AAPCHO
Association of Asian Pacific Community Health Organizations

NATIONAL ASSOCIATION OF Community Health Centers

PRESENTATION OVERVIEW

1. What is PRAPARE?
2. PRAPARE Data Findings
3. PRAPARE Data Resources
4. Q&A

PRAPARE

What is PRAPARE?

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences

A national **standardized** patient risk assessment **protocol** designed to **engage patients** in assessing and addressing social determinants of health

PRAPARE

💡 Poll

Poll Question: Does your organization currently use the PRAPARE® SDOH tool?

Yes
No
Not Sure

What does PRAPARE Measure?

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

30+ translations of PRAPARE now ava e!

Core

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

Optional

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

Optional Granular

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

* UDS measures are automatically populated into PRAPARE EHR templates.

Find the tool at https://prapare.org/

PRAPARE

Why use PRAPARE to collect SDOH?

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

ACTIONABLE

STANDARDIZED and WIDELY USED

EVIDENCE-BASED and STAKEHOLDER-DRIVEN

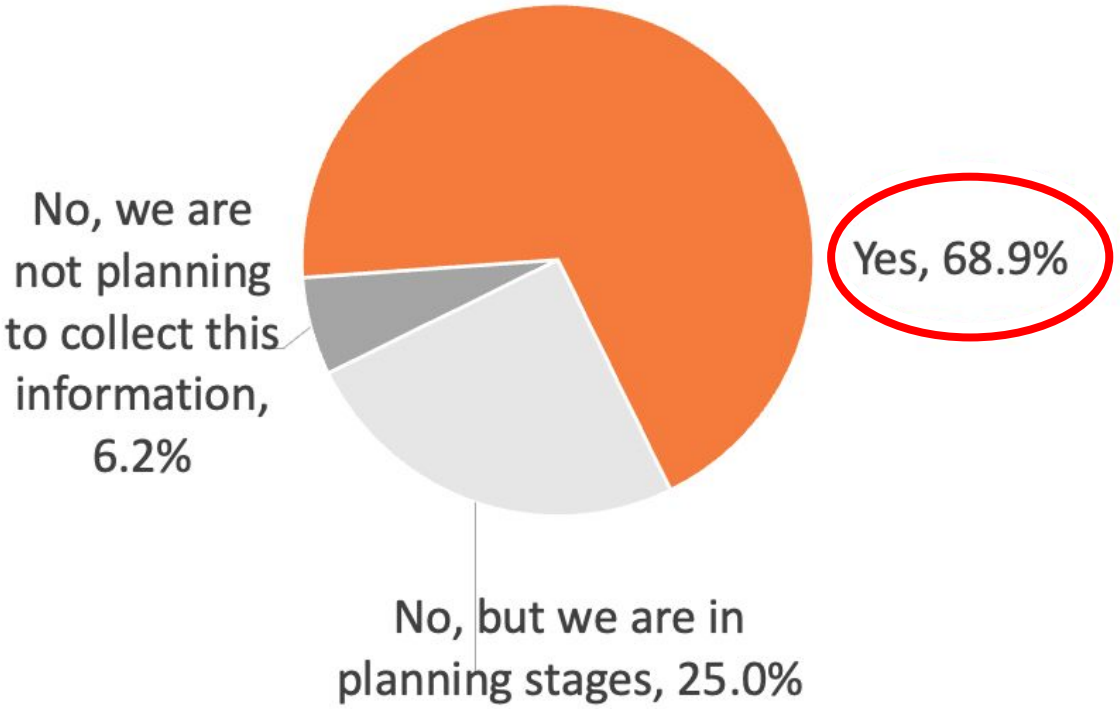
DESIGNED TO ACCELERATE SYSTEMIC CHANGE

PATIENT-CENTERED

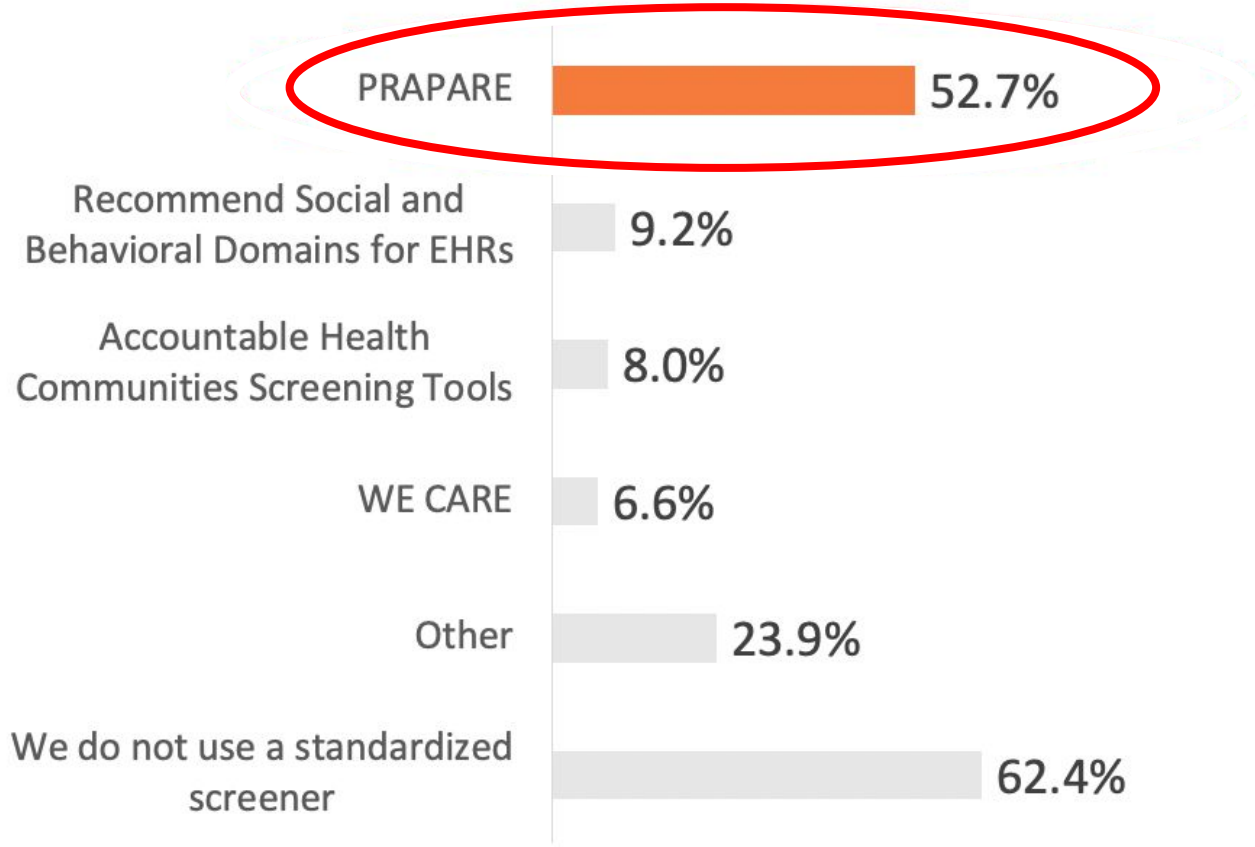
National SDOH Screening 2020-UDS

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Does your health center collect data on individual patients social risk factors, outside of the data reportable in the UDS?



Which standardized screener(s) for social risk factors, if any, do you use?



National PRAPARE Use 2020

http://bit.ly/PRAPAREMap2020

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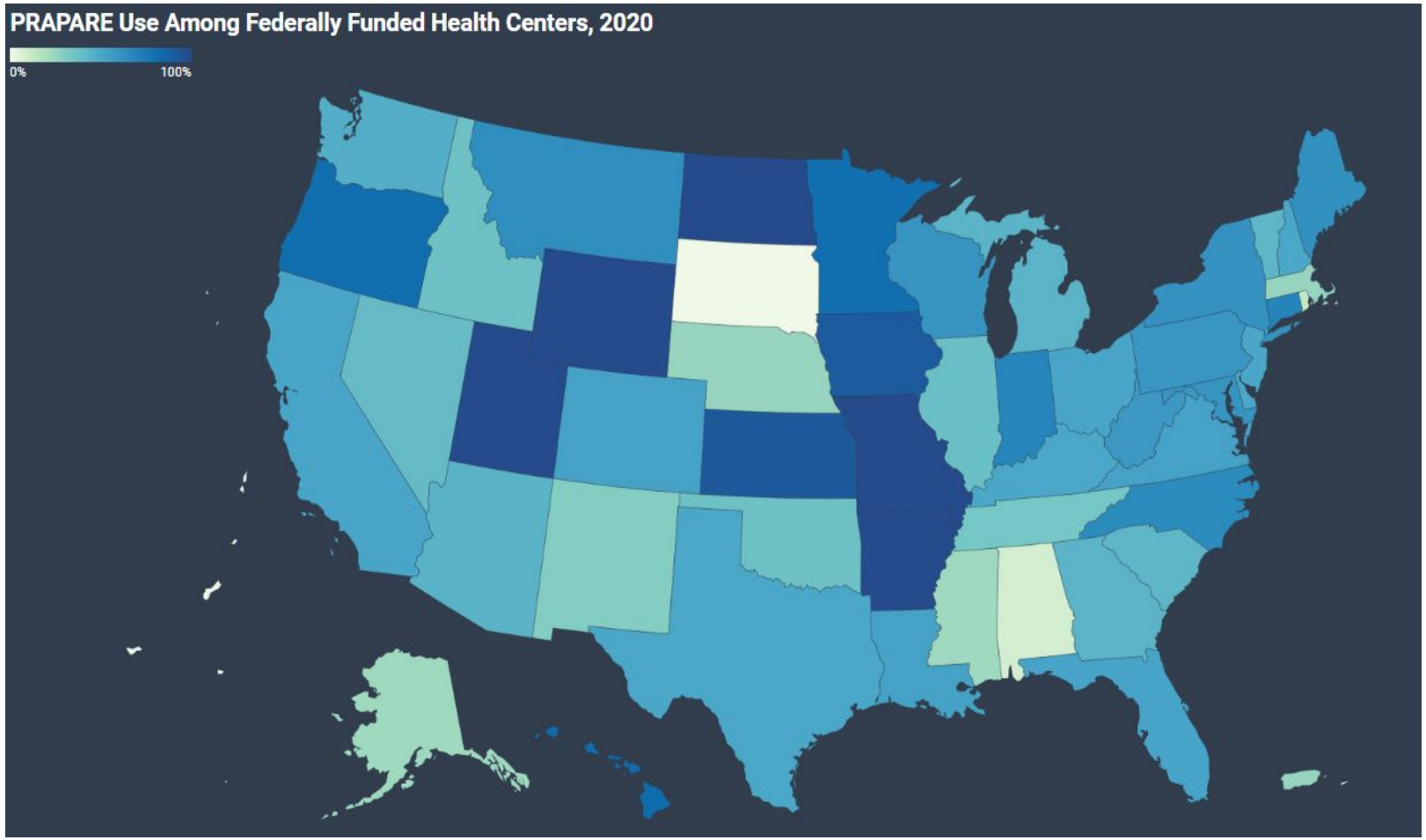

Note: Percentages reflect PRAPARE use among federally funded health centers that report screening for social risk. Excludes Health Center Program Look-Alikes and may underestimate the true volume of federally funded health centers using PRAPARE. For example, data may not capture all health centers accessing PRAPARE through some Electronic Health Records or other Health Information Technology platforms and does not capture health centers using parts of PRAPARE.

Source: 2020 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, DHHS.

Why Collect Standardized Data on SDOH?

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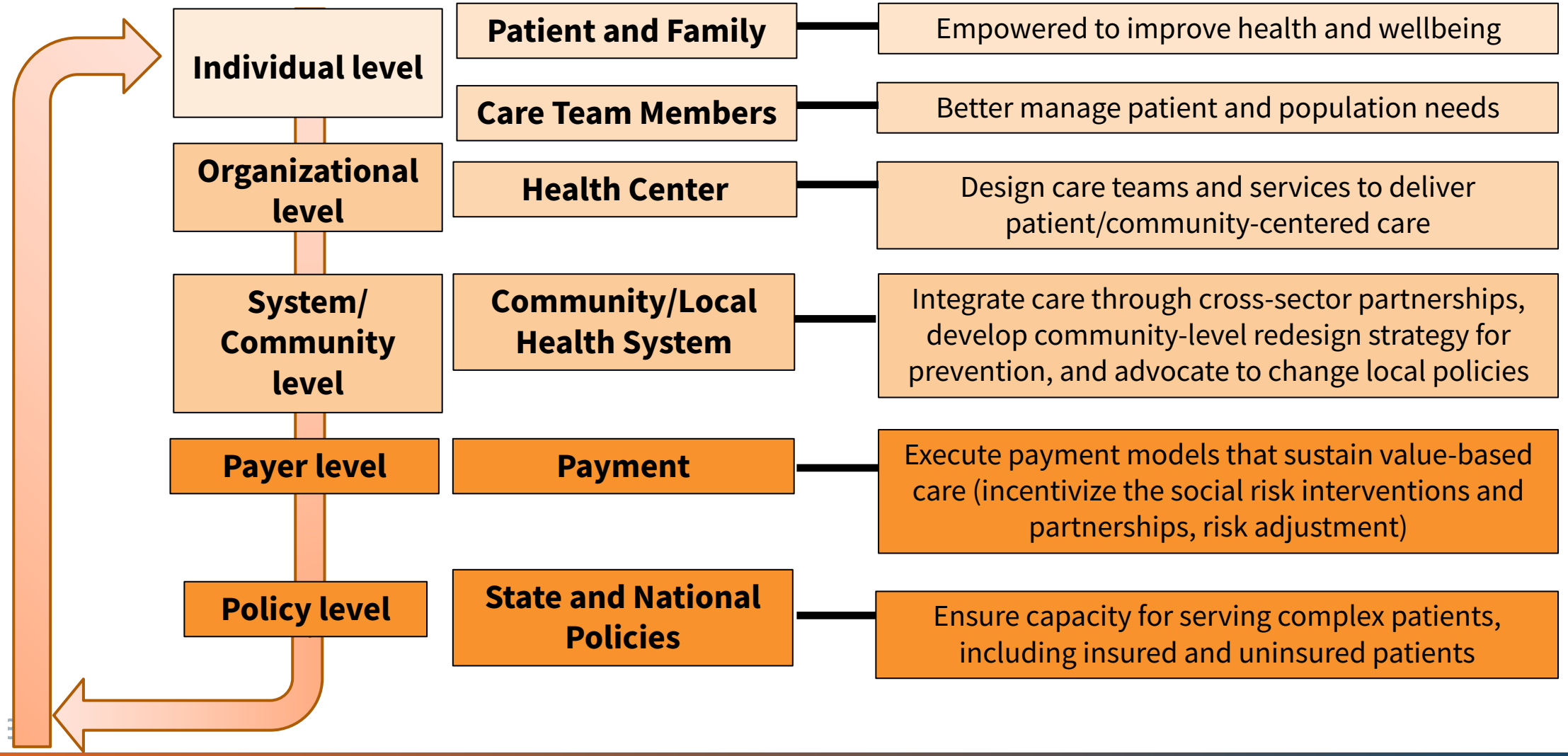

💡 Poll

Poll Question: Does your organization share SDOH data with care team members?

Yes
No
Not Sure

NATIONAL ANALYSES

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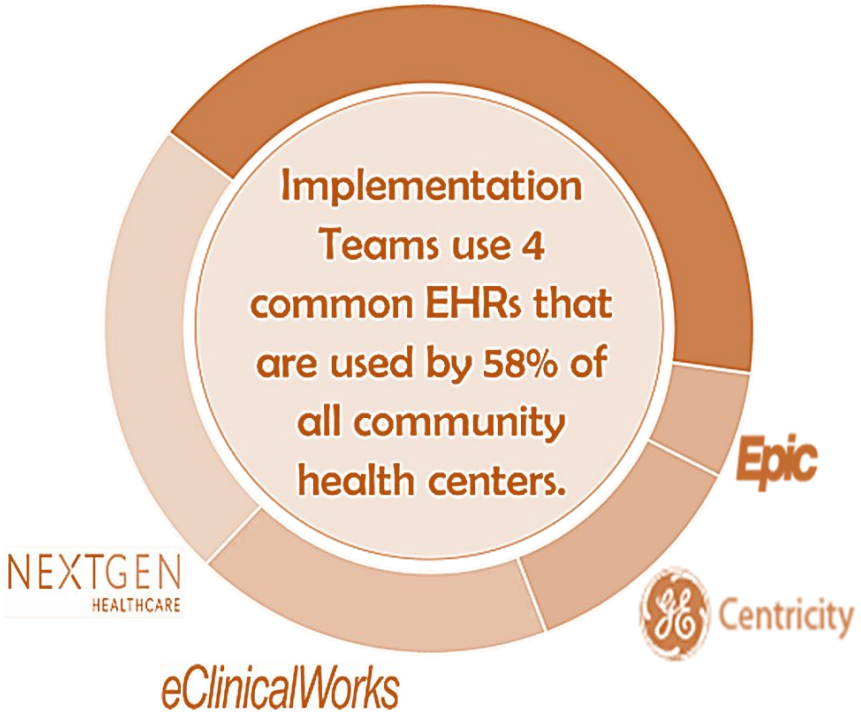
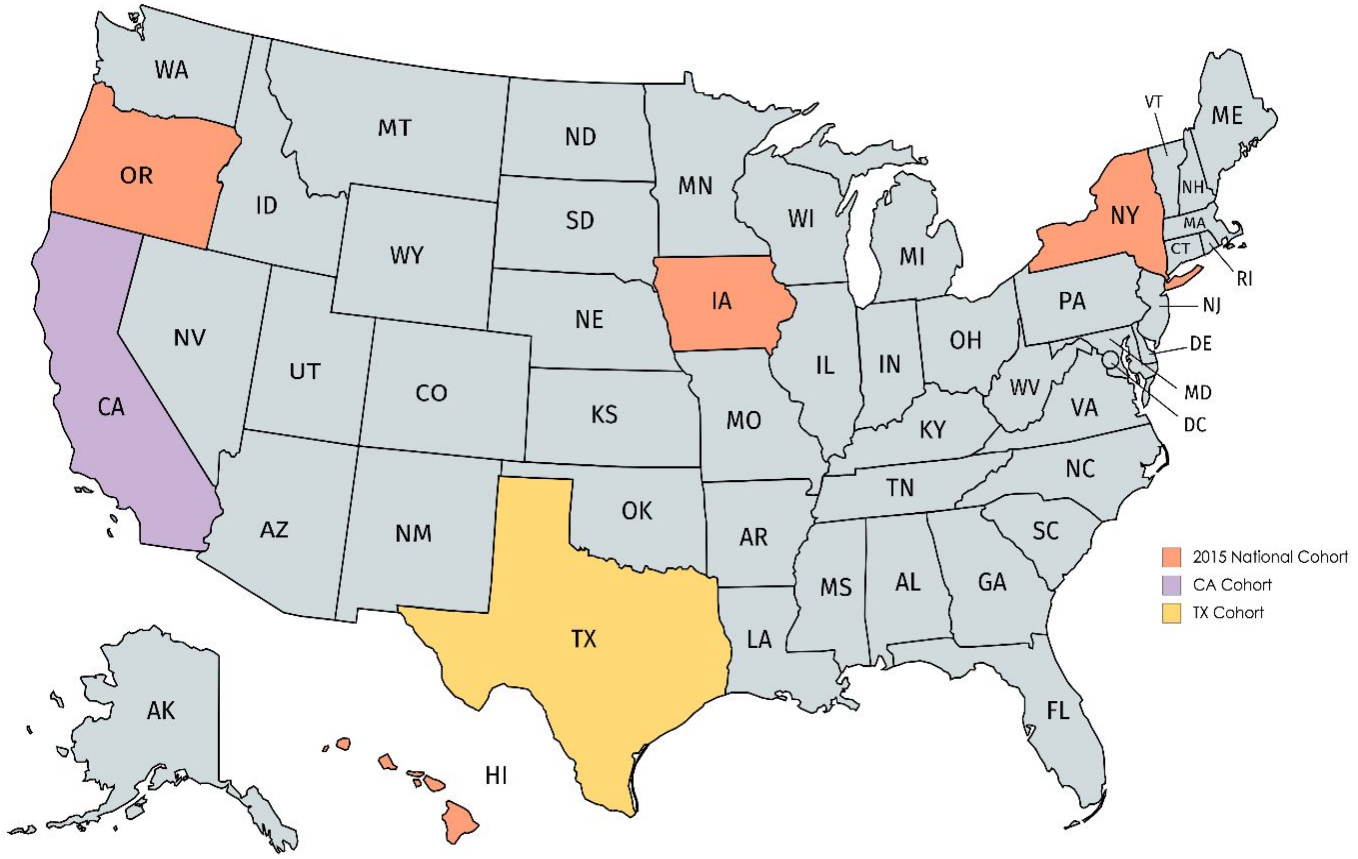
PRAPARE PILOTS





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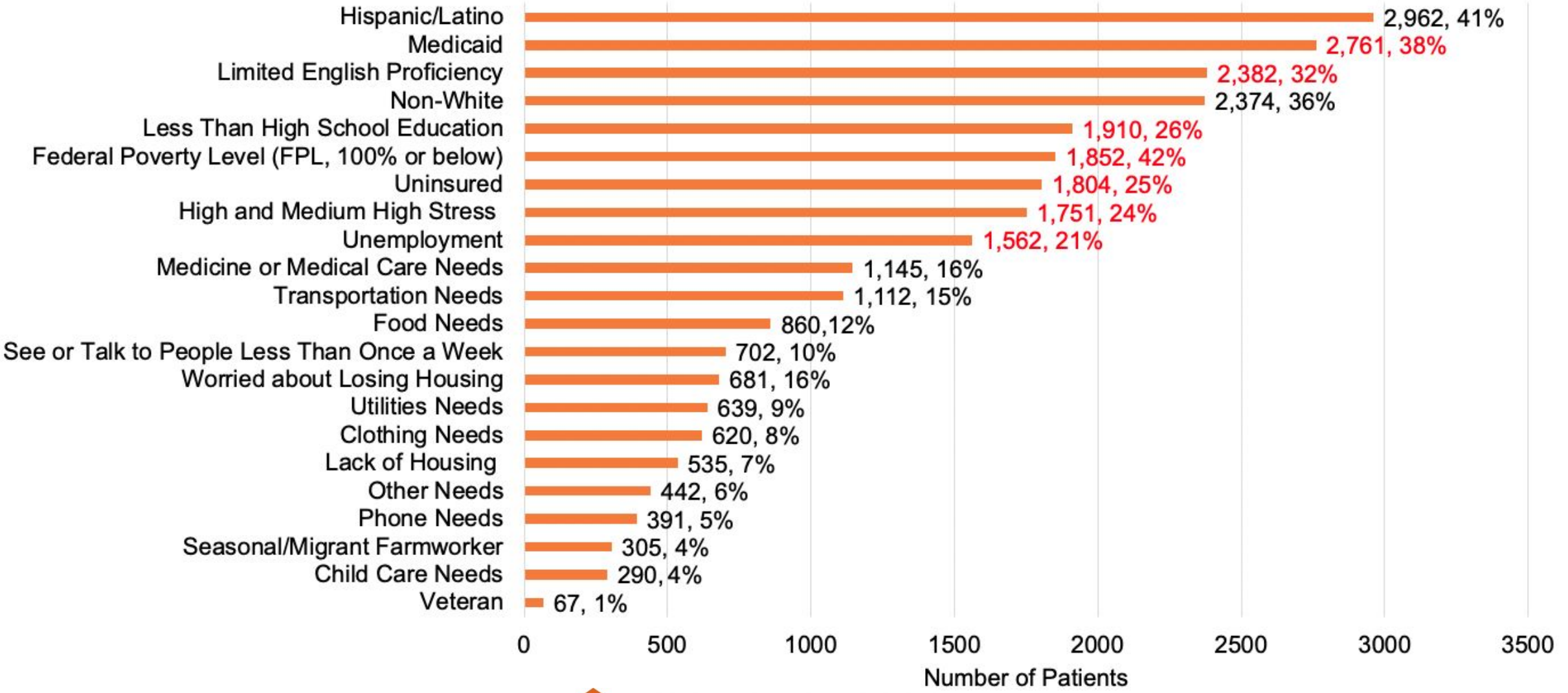
Frequency of SDOH among all Cohorts



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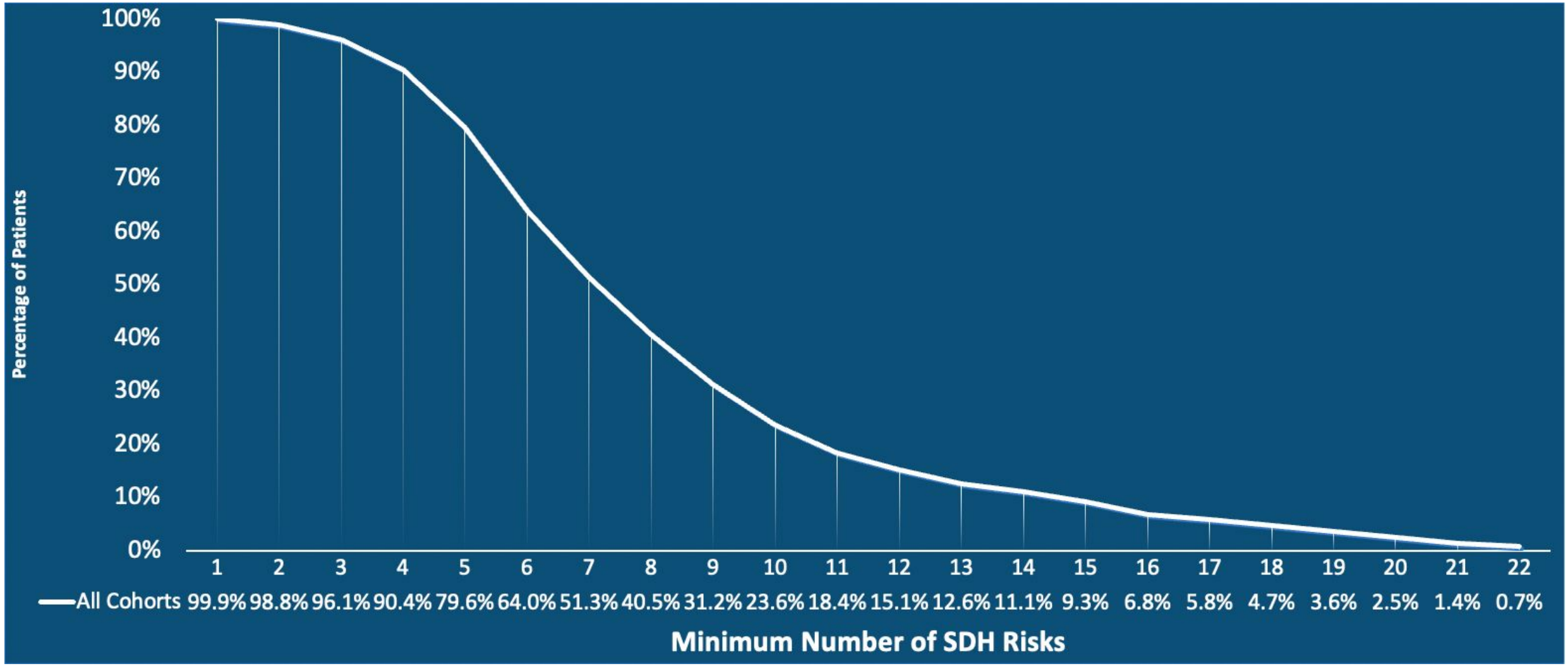
Distribution of Patients by Minimum Number of SDOH Risks



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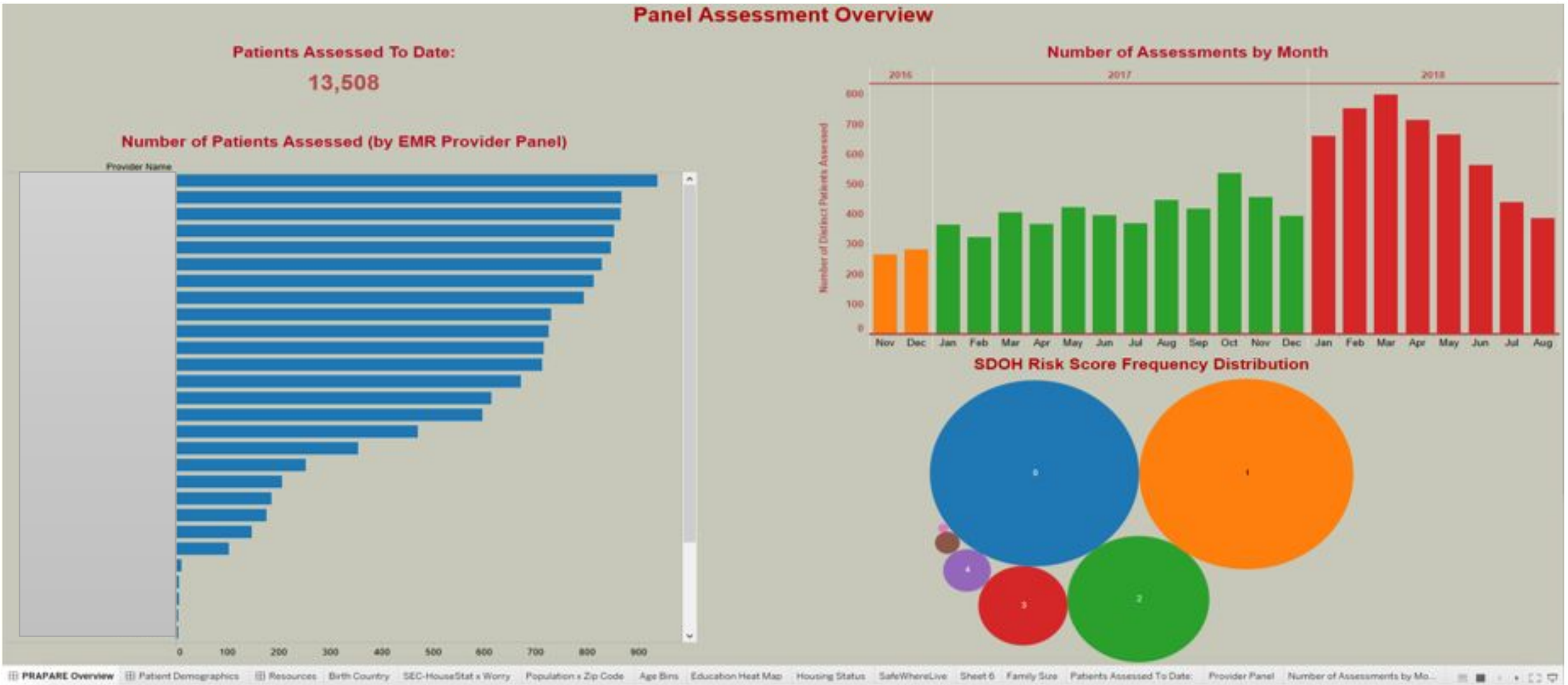
💡 Zoom Chat

Chat Question: How does your organization use SDOH data?

PRAPARE DATA VISUALIZATION:
Use at Team Huddles, Staff Meetings, etc.



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CONTROLLED VS UNCONTROLLED DIABETES

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IMPACT OF PRAPARE SDOH ON CONTROLLED VS UNCONTROLLED DIABETIC PATIENTS

- Sample: Patients diagnosed with diabetes from one health center in Iowa in a one-year PRAPARE implementation period (9/12/2016 - 9/13/2017)

Controlled Diabetics	Uncontrolled Diabetics	Total Population
986 patients	**221 patients**	**1,207 diabetic patients**

- t-tests to compare social determinant risks of controlled diabetics (HbA1c < 9) vs uncontrolled diabetics (HbA1c >= 9)

- Logistic regression analysis to assess relationship between number of social determinant risks and likelihood of being uncontrolled diabetic

PRAPARE

UNCONTROLLED DIABETICS HAD SIGNIFICANTLY MORE SOCIAL DETERMINANT RISKS THAN CONTROLLED DIABETICS

Social Determinant	% of Uncontrolled Diabetics with Social Determinant	% of Controlled Diabetics with Social Determinant	
Stress	**55%**	**46%**	P-value < 0.05
Challenge accessing care (includes behavioral health, dental, medical care)	**33%**	**17%**	
Food insecurity	**20%**	**13%**	
Lack of Housing	**12%**	**7%**	
Worried about Losing Housing	**11%**	**7%**	
Phone Needs	**12%**	**8%**	
Utility Needs*	**12%**	**9%**	P-value < 0.10
Transportation*	**20%**	**15%**	
Safety Needs* **("Do you feel physically & emotionally safe where you currently live?")**	**8%**	**4%**	
Legal Aid Needs*	**8%**	**5%**	

- Indicates marginal significance ($p < 0.10$).

Percentages are out of known responses.

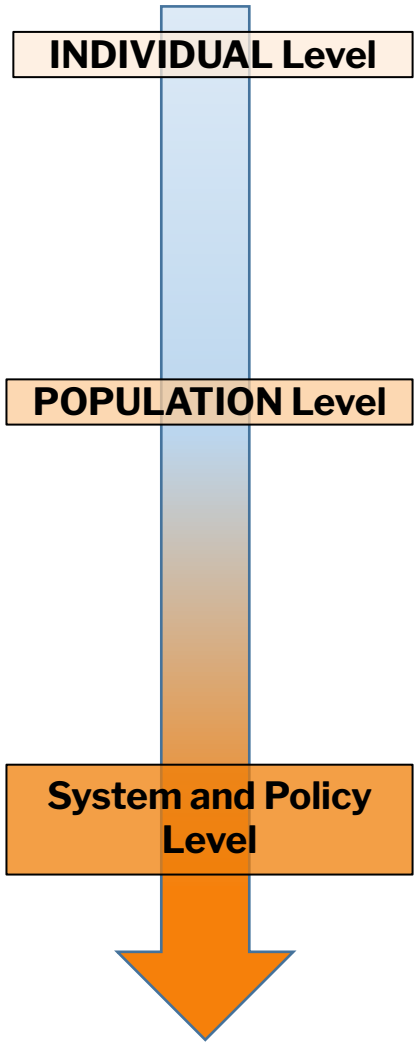
PRAPARE

💡 Zoom Chat

Question:

Chat Question: What are barriers and potential solutions to using SDOH data?

HOW PRAPARE DATA HAS BEEN USED TO IMPROVE CARE DELIVERY AND HEALTH OUTCOMES



INDIVIDUAL Level	Build new or expand existing services in-house for same-day use as clinic visit (children's book corner, food banks, clothing closets, wellness center, transportation shuttle, etc)	Ensure prescriptions and treatment plan match patient's socioeconomic situation (all)
POPULATION Level	Build partnerships with local organizations (transportation partnerships)	Guide work of local foundations (ex: New York housing)
	Use for Population Segmentation/Risk Stratification	Streamline care management plans for better resource allocation (ex: Hawaii)
System and Policy Level	Inform health delivery redesign (ex: Medicaid and Medicare ACO discussions)	Calculate ROI for social determinant interventions and revenue generated from reducing no-show rates
	Use data for "seat at the table" with payers to discuss sustainable payment and APM	

PRAPARE

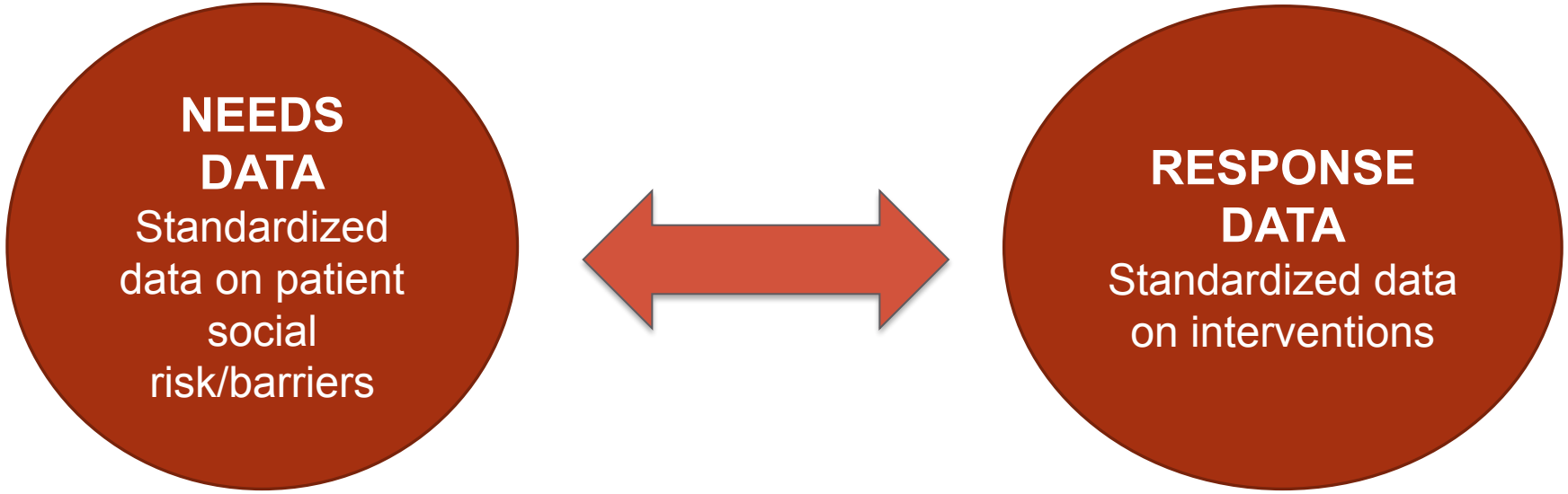
Publication pending. Do not quote or distribute without permission from NACHC.

Enabling Services = Social Interventions

Social Interventions = Non-clinical services that address non-medical, health-related social determinant of health needs

-Adapted from National Academies of Sciences, Engineering, and Medicine report, 2019

Why are Social Interventions important?



BOTH are necessary to:

- ✔ Increase community capacity to recognize hidden disparities and proactively address SDOH with effective social interventions
- ✔ Demonstrate community value of social interventions for equity
- ✔ Provide necessary evidence to achieve adequate financing for interventions to address equity
- ✔ Align sectors to better coordinate patient care to comprehensively address the root causes of health inequities
- ✔ Achieve integrated, value-driven delivery system and reduce total cost of care

Social Intervention Response: Activity Codes

Code	Social Intervention Activity	Definition
AM001	Assessment	Social assessment used as a followup to a positive PRAPARE response or social need that includes the use of an acceptable instrument measuring socioeconomic status, wellness, or other non-medical health status.
CM001	Social Care Management	An encounter with a patient or their household or family member in which a comprehensive patient-centered social care plan is developed or monitored to address a positive PRAPARE response or social need. The care plan focuses on supporting patients in meeting social service needs of the patients and may include a followup plan to close the social service loop.
RF001	Referral	Facilitation of a visit with a patient to a social service provider. Includes re-referrals if necessary.
RF002	•Follow up on Social Service Closed Loop, Referral Status	Follow up with a patient who was previously referred to an external organization or other department. Please indicate care team followup status of social intervention using the following categories: 0 = Patient social need was not met and requires followup to address social need (select reason) a. Patient has not yet followed up with referral dept/organization b. Patient unable to be served at referral dept/organization c. Patient lost to follow up d. Other, please specify:_____ 1 = Patient social need was met through social intervention 2 = Patient no longer needs service e. Patient used different organization f. Patient chose not to use referral resource g. Patient situation changed and no longer needs service h. Patient requested not to be called again i. Other, please specify:_____ 3 = Other, please specify:_____

Social Intervention Response: Activity Codes (cont)

Code	Social Intervention Activity	Definition
EA001	Eligibility Assistance	Counseling of a patient and assessing the patient's eligibility of a program to address a social need.
ED001	Education	The provision of learning experiences in an encounter designed to help individuals improve their social health, including: describing appropriate use of social services, teaching self-management approaches, explaining how to prevent injuries for patients, and other promoting behaviors to address social needs.
SC001	Supportive Counseling	The provision of support to patients to mitigate distress or concerns regarding issues affecting their social wellbeing. This would include listening to patient concerns and providing encouragement when appropriate.
IN001	Interpretation	Provision of interpreter services by a third party (other than the service provider) intended to reduce barriers to a limited English-proficient (LEP) patient or a patient with documented limitations in writing or speaking skills sufficient to affect the outcome of an encounter.
OT001	Outreach	Providing information about social services to engage patients to address social need(s) including checking in with a patient to close the social service loop in order to ensure appropriate and timely social service.
TR001	Transportation	Providing transportation assistance to a patient requiring transport to receive appropriate social services.
OT001	Other Social Intervention Activity: Please Specify (OPTIONAL)	If the social intervention does not fall into the above categories, please enter free text name and description of other social intervention. This is REQUIRED if the social intervention service type field "Other" is marked.

💡 Poll

Poll Question: Does your organization track social interventions, referrals, and/or other services you provide to address social needs (e.g., transportation, interpretation, case management for social needs, housing services, services that address food insecurity, assistance seeking employment, etc.)?

Yes
No
Unsure

Examples of Reporting Metrics

- **# of positive SDOH screens and corresponding social interventions by month, by category & provider type**
- **# of SDOH interventions addressed compared to number of remaining positive PRAPARE needs**
- **Top patient SDOH needs that lack community resources/interventions**
- **Understanding of Labor: Mean length of time spent on social interventions, by category & provider type**
- **Summary of patient referral status (e.g. completed, lost to follow up etc) by social intervention, by organization**

Resources, Q&A, and Closing

NATIONAL ASSOCIATION OF Community Health Centers®

AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

Resources Available to Support PRAPARE Implementation

- ✔ Free PRAPARE Implementation and Action Toolkit
- ✔ Free EHR templates for Cerner, eCW, Epic, GE Centricity, Greenway, NextGen
  - ✔ More EHR templates in progress! Athena, Allscripts, Meditab
- ✔ PRAPARE Readiness Assessments
- ✔ Recorded Webinars on PRAPARE, Workflows, EHR Templates, Responding to Interventions, etc.
- ✔ 10 translations of PRAPARE including Spanish, Somali, Arabic, Chinese, Tagalog, Korean, Vietnamese, and more!
  - ✔ 16 more translations on the way!
- ✔ Case Studies and User Stories

Available at prepare.org

PRAPARE

PRAPARE

Resources Available to Support PRAPARE Data Use

- ✔ Free PRAPARE Implementation and Action Toolkit
- ✔ PRAPARE Show and Tell Templates - **Show off PRAPARE SDOH Data at Your Health Center!**
  - ✔ **Includes User Guide, Handout/Poster Data Templates, and Examples**
- ✔ PRAPARE Opportunities to Leverage Data for Action
- ✔ PRAPARE National Data Findings
- ✔ PRAPARE Data - Impact on Diabetes and Hypertension
- ✔ PRAPARE Data - High Risk Populations
- ✔ PRAPARE Risk Stratification
- ✔ PRAPARE Validation Fact Sheet
- ✔ Case Studies and User Stories
- ✔ Checkout PRAPARE Knowledge & Resource Center for more!

New Website! Available at https://prapare.org/

QUESTIONS AND ANSWERS

PRAPARE

QUESTIONS

National Center for Medical Legal Partnership

AT THE GEORGE WASHINGTON UNIVERSITY

Tips for assessing social needs

- Review data from existing screening tool(s)
- Speak with staff & clinicians in each dept
- Take stock of existing priorities & capacity
- Examine EHR data to help identify / determine volume of potential priority patients
- If necessary/feasible, do separate legal needs assessment

Which of the needs you identified have legal solutions?

Happening Soon!

Subscribe to our **newsletter** to stay up-to-date on our events and resources.

bit.ly/mlpnews

THANK YOU!

Please take a moment to complete our survey. Link is in the chat.