Six Steps to Hospital Health Equity Action Planning

Rosa Abraha, MPH, Alliant Health Solutions
October 19, 2023
Rosa Abraha, Alliant Health Solutions

Rosa joined Alliant in December 2021 to lead the company’s first health equity strategic portfolio and embed health equity in the core of Alliant’s work.

Rosa has 10 years of experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA). She holds a Master of Public Health in Health Policy and Management from Emory University.

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Six Steps for Hospital Health Equity Action Planning

Step 1: Identify your health equity champion and team, including leadership

Step 2: Solidify a process for collection of REaL & SDOH data and embed it into EHR

Step 3: Stratify and analyze your REaL & SDOH data by quality measures

Step 4: Utilize your data to identify and address 1-2 priority populations experiencing health disparities

Step 5: Develop concrete health equity goals with short and long-term action steps to address your identified disparities

Step 6: Develop community partnerships that focus on reducing your identified disparities
## Step #1: Hospital Leadership Engagement and Health Equity Team

<table>
<thead>
<tr>
<th>CMS HCHE</th>
<th><strong>Mandatory CY23</strong></th>
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</thead>
<tbody>
<tr>
<td>**MUC 2021-106</td>
<td>Domain 5A**</td>
</tr>
<tr>
<td>Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.</td>
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<table>
<thead>
<tr>
<th>TJC</th>
<th><strong>Mandatory 1/1/24</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Standard LD.04.03.08</strong></td>
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<tr>
<td>Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority.</td>
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<tr>
<td><strong>EP 1</strong></td>
<td></td>
</tr>
<tr>
<td>The [organization] designates an individual(s) to lead activities to reduce healthcare disparities for the [organization's] [patients].</td>
<td></td>
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</tbody>
</table>
Building Your Baseline Health Equity Team

You may not have a big hospital or large teams so at minimum your hospital health equity team could include the following key personnel if you have them:

- Case Management
- Quality Team
- Registrar Team
- Social worker(s)
- Involved department leadership
  - i.e., ED, MedSurg, Rehabilitation, Swing bed

- Hospital Staff Pertaining to the 5 CMS SDOH Domains:
  - **Food Insecurity**: Dietary/Nutrition Dept., swing bed
  - **Transportation**: EMS, Paramedics, ED
  - **Homelessness**: Social worker, discharge planners, swing bed
  - **Utility Difficulties**: Social worker, discharge planners, swing bed
  - **Interpersonal Violence**: Social worker, discharge planners, swing bed
  - **All Domains**: Language line interpretation services/personnel
## Model Structure for Your Hospital Health Equity Team

<table>
<thead>
<tr>
<th>Role</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Senior Leadership</td>
<td>John Doe</td>
</tr>
<tr>
<td>Quality Team Members</td>
<td>John Doe</td>
</tr>
<tr>
<td>Case Management Team Members</td>
<td>John Doe</td>
</tr>
<tr>
<td>Physician Team Members</td>
<td>John Doe</td>
</tr>
<tr>
<td>Registration Team Members</td>
<td>John Doe</td>
</tr>
<tr>
<td>Patient and Family Advisory Council –</td>
<td>John Doe</td>
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This is an example model for structuring your hospital health equity team. Insert names of people on your team in the boxes to the right. This team should be meeting on a recurring basis (monthly, quarterly etc. to plan and execute health equity activities.
Step #2: Data Collection - REaL and SDOH Patient Demographic Data

CMS HCHE

Mandatory CY23

- MUC 2021-106
  - Domain 2A
    - Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients.
  - Domain 2B
    - Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.
  - Domain 2C
    - Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.

TJC

Mandatory 1/1/24

- Standard RC.02.01.01
  - The [medical] record contains information that reflects the [patient’s] care, treatment, and services.
- EP 2B
  - The medical record contains the patient’s race and ethnicity.
Data Collection: 5 CMS Domains of SDOH Screening

1. **Food Insecurity**
   Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.

2. **Housing Instability**
   Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.

3. **Transportation Needs**
   Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

4. **Utility Difficulties**
   Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.

5. **Interpersonal Safety**
   Assessment for this domain includes screening for exposure to intimate partner violence, child abuse, and elder abuse.
Data Collection: Screening Patients for SDOH

CMS SDH
Voluntary CY23
Mandatory CY24

Screening for Social Drivers of Health MUC2021–136
Numerator: Number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance, and interpersonal violence.
Denominator: Number of beneficiaries 18 and older in practice (or population).

Screen Positive Rate for Social Drivers of Health MUC2021–134
Numerator: Number of beneficiaries 18 and older that screen positive for food insecurity, housing instability, transportation needs, utility assistance or interpersonal violence.
Denominator: Total number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance or interpersonal violence.

NOTES:
• These are both structural measures and the data can come from multiple sources (administrative claims data, electronic clinical data, standardized patient assessments, or patient-reported data and surveys).
• Exclusion criteria exists for patients who opt-out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.
• The screen positive rate will result in 5 unique rates for each of the 5 categories of social drivers of health.
CMS AHC HRSN - SDOH Screening Tool

- CMS and CMMI developed the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool.

- It is recommended to use this form and integrate the questions into your EHR as it contains 2 questions in each of the 5 core domains that CMS will be evaluating for both structural measures (SDOH-1 and SDOH-2).

- This tool is currently embedded into EPIC EHR.

What data do you already collect and how is it collected?
• Example: Race, Ethnicity and Language (REaL) Data
  • Self-reported at registration

What data do need to start collecting to meet CMS standards and how do you plan to do that?
• SDOH Data
  • Example: Patient screen completed by admitting nurse for all incoming patients. Case Management consult triggered when a patient screens positive for the SDOH domains

Information Systems:
• Does your EMR have a custom report built into it for collecting this data into a report? If not, please contact your EMR provider to request that information so you can track monthly data trends.
**Step #3: Data Analysis and Stratification by Hospital Quality Measures**

### CMS HCHE
**Mandatory CY23**

**MUC 2021-106**
- **Domain 3A**
  - Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.
- **Domain 1B**
  - Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

### TJC
**Mandatory 1/1/24**

**Standard LD.04.03.08**
- Reducing healthcare disparities for the [organization’s] [patients] is a quality and safety priority.
- **EP 3**
  - The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization’s] [patients].
Example Process for Health Equity Data Analysis

1. Stratify admissions data by REaL data
2. Disaggregate readmission data by REaL data and compare to admissions data
3. Stratify priority population by top DRGs or CMS conditions for admissions and readmissions
4. Stratify top DRG/CMS condition for priority population by SDOH domains
5. Display identified equity gaps on performance dashboard

• These steps exist to ensure removal of medical bias and selection bias.
• The main goal is to eliminate assumptions about who your priority populations are and what the root-cause of their disparities might be.
• Instead, we want to allow the data to drive our priority populations of focus and in turn the interventions, resources and community partnerships necessary to provide the best and most trusted care to those patients.
1. All Admissions by Race/Ethnicity

2. All Readmissions by Race/Ethnicity

3. Black/African American Males Readmissions, Heart Failure

4. SDOH screening revealed food insecurity and transportation needs for readmitted population
What are key CMS conditions that your hospital needs to improve upon?
• Example: 30-day All Cause Readmissions
• Are there are any more to think about?

How will you map these CMS conditions against REaL and SDOH data?
• See slide 16 as an example for how to do this for readmissions. Write out your steps in and feel free to tweak them to make sense for your hospital.

How will you embed this data into your hospital dashboards?
• Should this be built into custom dashboards that are pre-existing?
Step #4: Health Equity Priority Population

**CMS HCHE**

Mandatory CY23

MUC 2021-106

**Domain 1A**

Our hospital strategic plan identifies priority populations who currently experience health disparities.

**Domain 1B**

Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.

**Domain 1C**

Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.

**TJC**

Mandatory 1/1/24

Standard LD.04.03.08

Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority.

EP 4

The [organization] develops a written action plan that describes how it will address at least one of the healthcare disparities identified in its [patient] population.

EP 5

The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce healthcare disparities.
Focus on Priority Populations in the Five CMS Domains of SDOH Screening

1. Food Insecurity
   Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.

2. Housing Instability
   Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.

3. Transportation Needs
   Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

4. Utility Difficulties
   Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.

5. Interpersonal Safety
   Assessment for this domain includes screening for exposure to intimate partner violence, child abuse, and elder abuse.
## Step #5: Health Equity Goals and Action Steps

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<td><strong>Mandatory CY23</strong></td>
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<td>CMS HCHE</td>
<td>TJC</td>
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<tr>
<td><strong>MUC 2021-106</strong></td>
<td><strong>Standard LD.04.03.08</strong></td>
</tr>
<tr>
<td>Domain 1A</td>
<td>Reducing healthcare disparities for the [organization’s] [patients] is a quality and safety priority.</td>
</tr>
<tr>
<td>Domain 1B</td>
<td>EP 4</td>
</tr>
<tr>
<td>Our hospital strategic plan identifies priority populations who currently experience health disparities.</td>
<td>The [organization] develops a written action plan that describes how it will address at least one of the healthcare disparities identified in its [patient] population.</td>
</tr>
<tr>
<td>Domain 1C</td>
<td>EP 5</td>
</tr>
<tr>
<td>Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.</td>
<td>The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce healthcare disparities.</td>
</tr>
<tr>
<td>Domain 1C</td>
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</table>
Critical Elements for a Hospital Health Equity Strategic Plan

• Executive Summary
  • This should include that this is a Board approved health equity strategic plan for the purposes of achieving the CMS/TJC health equity standards

• Background on County Level and Hospital Level Demographic or SDOH Data
  • Pull data from the Department of Public Health or other publicly available reports that list General Demographic Statistics (Age, race, disability status), SDOH statistics (high school educated, per capita income etc.) and chronic disease statistics (diabetes prevalence, infant mortality, and any CMS conditions)
  • Also pull hospital level data

• Health Equity Statement
  • Ex. To improve patient health outcomes and reduce healthcare disparities through data-driven health equity interventions and quality services

• Strategic Goals (discussed in more detail next slide)
  • Focus on meeting the CMS standard requirements
  • Include short- and long-term action steps with dates to achieve each goal

• Priority Population Health Equity Goals
  – If you don’t already have your priority population identified, describe the steps for how you will do that and what you plan to do once you have identified them (see slide 17-19)

• References
Main goal categories that Rosa recommends:

- Promote a culture of health equity that improves the quality, safety, and effectiveness of health services for underserved populations and those experiencing health disparities
- Collect and evaluate race, ethnicity and language (REaL) data and social determinant of health (SDOH) data to conduct a root-cause analysis in patient outcomes and drive evidence-based interventions
- Develop culturally and linguistically responsive healthcare interventions that promote health equity and adequately train hospital staff in identified best practices
- Bolster integral community partnerships to identify community assets that can help address patients’ health related social needs, especially in the five CMS SDOH domains (i.e., housing instability, transportation needs, utility difficulties, interpersonal safety and food insecurity)

Each goal must have short-term (next 3-6 months) and long-term action steps (next 6-12 months)

- Ex. Goal #3: Culturally and Linguistically Responsive Healthcare Interventions
  - **Short-Term Action:** By December 2023, provide mandatory health equity training via HealthStream across the case management team, registration staff, nursing staff and all necessary service lines utilizing the Alliant Health Solutions trainings, bite-sized learning videos and toolkits on health equity best practices and cultural and linguistic standards (CLAS).
  - **Long-Term Action:** By March 2024, review and improve discharge processes to include critical referral services for patients with social needs to appropriate community partner resources, especially in the five CMS SDOH domains (i.e., housing instability, transportation needs, utility difficulties, interpersonal safety and food insecurity)
Step #6: Health Equity Community Partnerships

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<tr>
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<tr>
<td>MUC 2021-106 Domain 4A</td>
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<tr>
<td>Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.</td>
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<thead>
<tr>
<th>CMS HCHE</th>
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<tbody>
<tr>
<td>MUC 2021-106 Domain 1D</td>
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<tr>
<td>Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.</td>
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<th>TJC</th>
<th>1/1/23</th>
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<td>Standard LD.04.03.08</td>
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<td>Reducing healthcare disparities for the [organization’s] [patients] is a quality and safety priority.</td>
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<td>EP 2</td>
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<tr>
<td>The [organization] assesses the [patient’s] health-related social needs and provides information about community resources and support services.</td>
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A Culture of Health Equity: Key Clinical-Community Partnerships

Example Clinical Partners
• Facilities (i.e., hospitals, nursing homes)
• Critical Service Areas (i.e., ED)
• Individual Clinicians and Critical Service Areas (i.e., ED, Case Management Team)
• Dialysis Centers
• Behavioral Health Clinics
• Social Services
• Pharmacies
• EMS

Example Community Partners
• United Way
• Area Agency On Aging
• Area Medicaid Reps
• Faith-Based Organizations
• Local Business (i.e., Barbershops, Grocery Stores)
• Local Employee Retiree Organizations
• Local Senior Centers
• Local Political Organizations
• Local Power Company
• Community Health Workers
• Local Transportation Agencies
• Housing Agencies
• Food Pantries/Shelters
• Literacy Volunteers
• Police and Fire Depts.
• Veterans Association
• Universities/Research Centers
Who are your trusted local community partner for addressing SDOH?
- Categorize your partner lists by the 5 SDOH domains
  - Example to the right from Tift Regional Hospital in GA

Who are your trusted statewide community partners for addressing SDOH?
- Ex. Alliant Health Solutions “Healthy Gulf Coast” Partnership for Community Health

Who are your trusted national partners for addressing SDOH?

Future Action Steps:
- Ex. Community Health Needs Assessment is a great opportunity to bring together potential partners to participate in the assessment. Include community leaders representing the diversity of your population.
Ways to Engage with Alliant Health Solutions Community Coalitions/PCHs

- Attend PCH meeting to learn what community outreach is going on in your region or state
- Engage with affinity or work groups – share best practices
- Use coaching calls to get questions answered
- Attend regional and statewide community coalition meetings
- Contact your AHS state quality manager below:

<table>
<thead>
<tr>
<th>State</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA</td>
<td>Carla Schuler</td>
<td><a href="mailto:Carla.schuler@allianthealth.org">Carla.schuler@allianthealth.org</a></td>
</tr>
<tr>
<td>TN</td>
<td>Julie Clark</td>
<td><a href="mailto:julie.clark@allianthealth.org">julie.clark@allianthealth.org</a></td>
</tr>
<tr>
<td>GA</td>
<td>Mel Brown</td>
<td><a href="mailto:melody.brown@allianthealth.org">melody.brown@allianthealth.org</a></td>
</tr>
<tr>
<td>NC</td>
<td>Marilee Johnson</td>
<td><a href="mailto:marilee.johnson@allianthealth.org">marilee.johnson@allianthealth.org</a></td>
</tr>
<tr>
<td>FL</td>
<td>Renee DelMonico</td>
<td><a href="mailto:renee.delmonico@allianthealth.org">renee.delmonico@allianthealth.org</a></td>
</tr>
<tr>
<td>KY</td>
<td>Leighann Sauls</td>
<td><a href="mailto:Leighann.sauls@allianthealth.org">Leighann.sauls@allianthealth.org</a></td>
</tr>
<tr>
<td>AL</td>
<td>Beth Greene</td>
<td><a href="mailto:beth.greene@allianthealth.org">beth.greene@allianthealth.org</a></td>
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CMS Attestation Guidance on Health Equity

For CY 2023 Reporting Period/FY 2025 Payment Determination

- For the CY 2023 reporting period/FY 2025 payment determination under the Hospital IQR Program, hospitals will need to confirm that they engaged in the activities described in this Attestation Guidance Document during the period of January 1, 2023, to December 31, 2023. If hospitals participate or complete qualifying activities at any time within the reporting year, they may answer yes to their attestation. Hospitals must complete their attestation for the CY 2023 reporting period/FY 2025 payment determination between April 1, 2024, and May 15, 2024.

- [https://qualitynet.cms.gov/inpatient/iqr/measures#tab2](https://qualitynet.cms.gov/inpatient/iqr/measures#tab2)

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<tr>
<td>Attestation Guidance for the Hospital Commitment to Health Equity Measure (06/2023)</td>
<td>PDF</td>
<td>485 KB</td>
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<tr>
<td>Hospital Commitment to Health Equity Structural Measure Specifications (06/2023)</td>
<td>PDF</td>
<td>305 KB</td>
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<td>Screening for Social Drivers of Health Measure and the Screen Positive Rate for Social Drivers of Health Measure (December 2022)</td>
<td>PDF</td>
<td>122 KB</td>
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<tr>
<td>Frequently Asked Questions: Social Drivers of Health (SDOH) Measures</td>
<td>PDF</td>
<td>281 KB</td>
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Alliant Health Solutions Health Equity Coaching Package

**HEALTH EQUITY COACHING PACKAGE**

**Purpose:** Use the evidence-based best practices and resources to create quality improvement action plans.

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<tr>
<td>Begin health equity journey with planning and preparation</td>
<td>Roadmap for Success: Implementing Equitable Care (HSAG HQIC, 2021)</td>
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<td></td>
<td>Health Equity Snapshot: A Toolkit for Outcomes</td>
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<td></td>
<td>The Health Equity Roadmap (AHA/IDHE)</td>
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<tr>
<td>Become familiar with federal and private sector definitions, standards and requirements for hospital health equity</td>
<td>CMS New SDOH Standards - Remington Report</td>
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<tr>
<td></td>
<td>NPSG.16-01.01 Improving health care equity for the hospital’s patients is a quality and safety priority</td>
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<td>CMS Health Equity Fact Sheet</td>
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<td>CMS Health Equity Programs</td>
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<td>CMS Framework for Health Equity 2022 - 2032</td>
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<td></td>
<td>The Joint Commission Health Equity R3 Report</td>
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<tr>
<td>Conduct an equity gap analysis</td>
<td>Health Equity Organizational Assessment (MHA)</td>
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<tr>
<td>Review resources on best practices for effective hospital health equity implementation</td>
<td>A Practical Guide for Implementing Hospital Health Equity - AHS HQIC LAN</td>
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<td></td>
<td>AHS Health Equity Presentation to Alabama Hospital Association</td>
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<td>Change Path of Health Equity Resources (Feb 28, 2023)</td>
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<td></td>
<td>Building an Organizational Response to Health Disparities (CMS, 2020)*</td>
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*Contains links to other resources

Cultural and Linguistically Appropriate Services
(Alliant Health Solutions CLAS Video Toolkit)

Health Literacy
Alliant QIO
4 videos 2 views Last updated on May 18, 2023

1. Health Literacy with Dr. Iris Feinberg, PhD, CHES
   Alliant QIO • 116 views • 3 months ago
   8:34

2. Bite-Sized Learning: Using Teach-Back
   Alliant QIO • 26 views • 8 days ago
   10:25

3. Bite-Sized Learning: CLAS 101
   Alliant QIO • 37 views • 1 month ago
   8:14

4. Bite-Sized Learning: CLAS Implementation
   Alliant QIO • 38 views • 1 month ago
   10:50

Source: Link

https://www.youtube.com/playlist?list=PLXWmxni-xNHvBQp3MQt8DXRae06CGF2Jl
Additional Resources

1. AHA Institute for Diversity and Health Equity https://ifdhe.aha.org/


4. The CMS Office of Minority Health (CMS OMH) released a new Z code infographic entitled: Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes (2023). This resource aims to assist providers with understanding and using Z codes to improve the quality and collection of health equity data.
Questions?

Email us at [HospitalQuality@allianthealth.org](mailto:HospitalQuality@allianthealth.org) or call us [678-527-3681](tel:678-527-3681).
Upcoming Events

Alliant HQIC Health Equity Planning Office Hours

Thursday, November 16, 2023
Thursday, December 21, 2023

3 – 3:45 p.m. EST

REGISTER HERE
Thank you for joining us!
How did we do today?