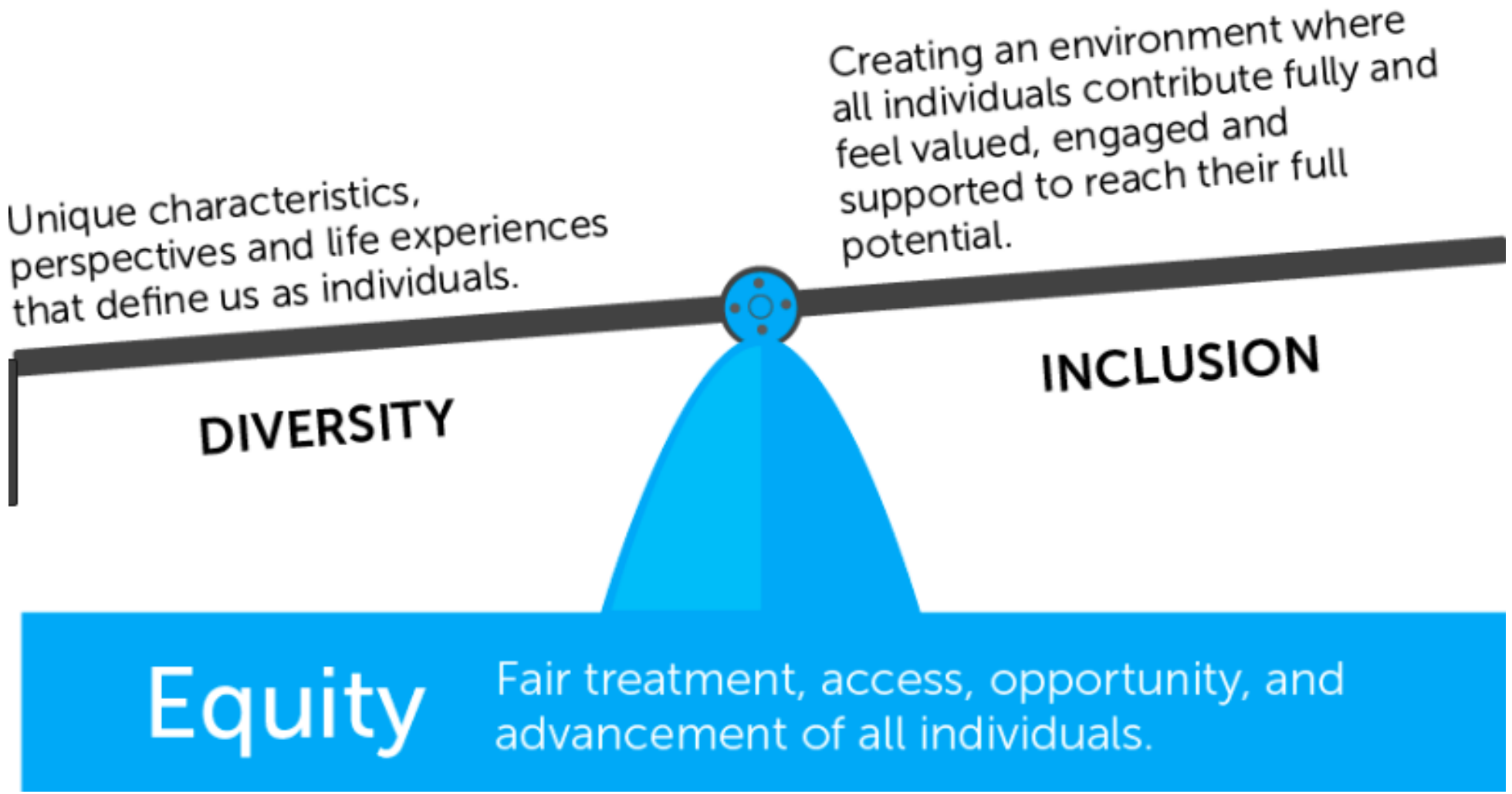
Centering Equity @ Institutional Level

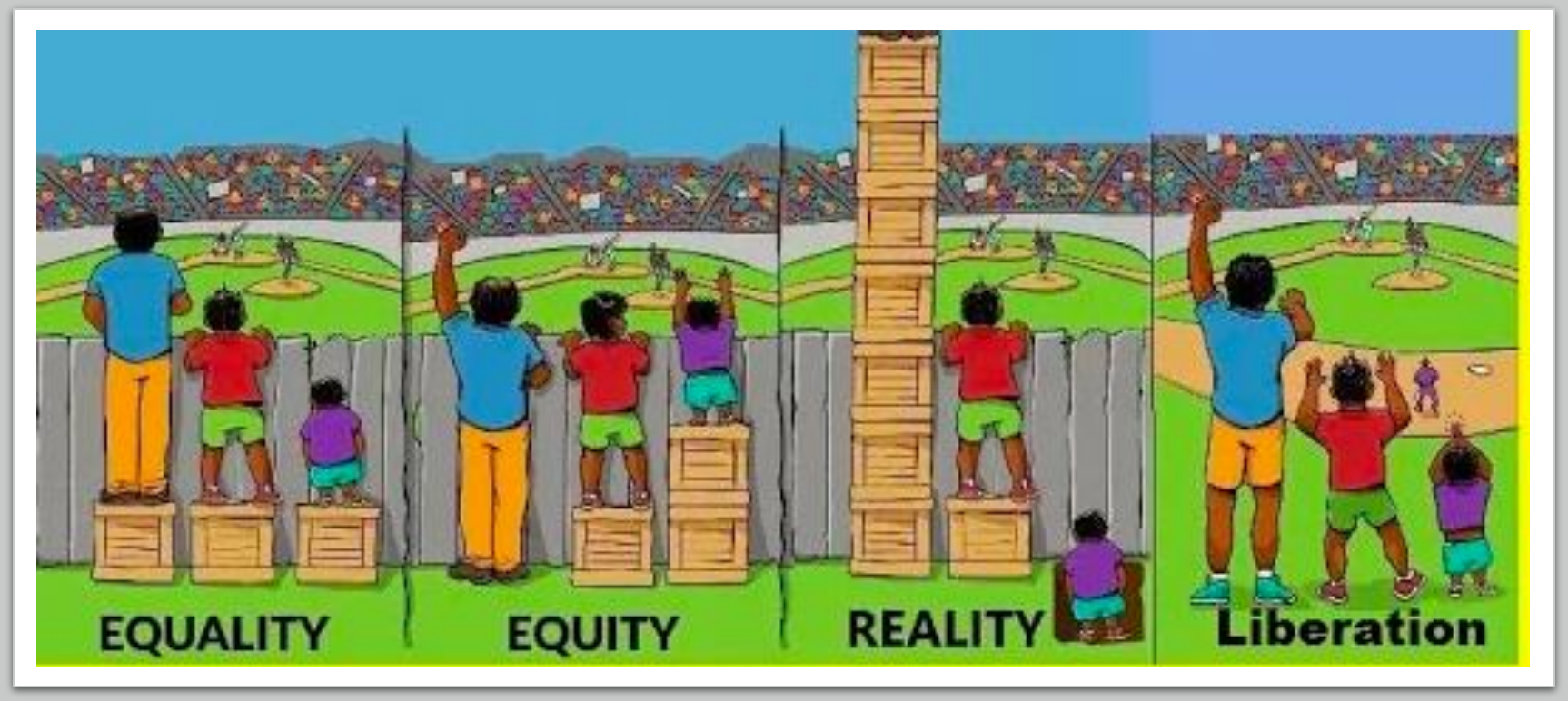
Aletha Maybank, MD, MPH
Chief Health Equity Officer
American Medical Association

Honoring Indigenous People

@the15WhiteCoats

permission received to use photo

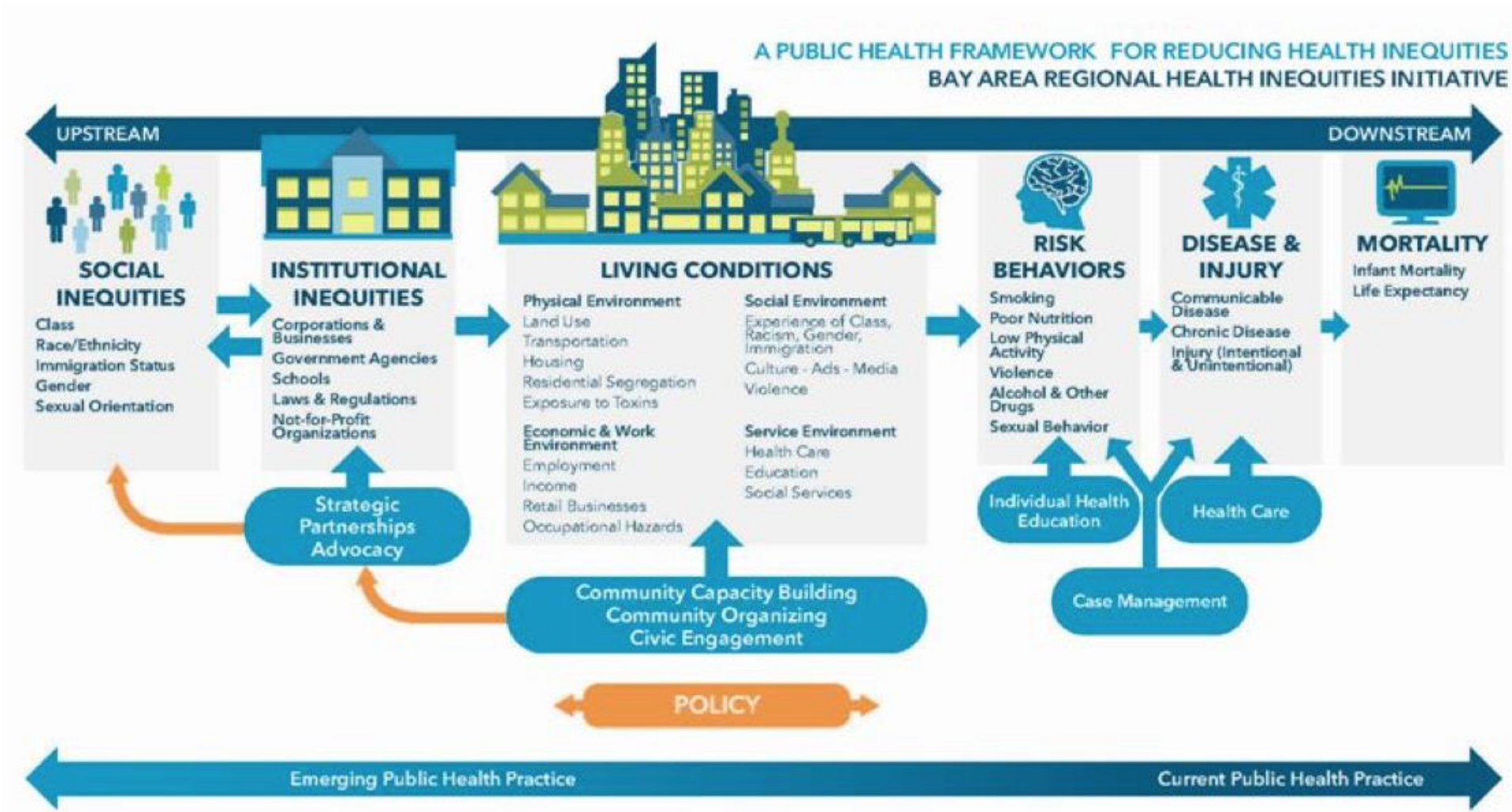




Health equity means…

Having the conditions, resources, opportunities, and power to achieve optimal health.

What creates health?



Source: Bay Area Regional Health Inequities Initiative (BARHII) Conceptual Framework, 2006.

What produces health inequities?

Terms	Common Definition	Populations targeted
Structural determinants / SDH inequities	***"The causes of the causes"*** The climate, the socioeconomic-political context (e.g. societal norms and macroeconomic, social, and health policies) and the structural mechanisms that shape social hierarchy and gradients (e.g. power, class, racism, sexism, exclusion).	Cities, states, nations, or the world, typically defined by political jurisdictions, cultural boundaries, or economic relationships.
Social determinants of health (SDH)	***"The causes of poor health"*** Underlying community-wide social, economic, and physical conditions in which people are born, grow, live, work, and age. • Systems that offer health, social services to a community are themselves a SDH. • As intermediary determinants, SDH shape individual material and psychosocial circumstances as well as biologic and behavioral factors.	Defined communities or regions, typically defined by geography.
Social needs / health-related social needs (HSRNs)	***"The effects of the causes"*** Individual material resources and psychosocial circumstances required for long-term physical and mental health & wellbeing. • Material resources: physical living and working conditions, factors such as housing, food, water, air, sanitation. • Psychosocial circumstances: stressors such as negative life events, stressful living circumstances, (lack of) social support.	Specific individuals or defined populations, typically defined by attribution.

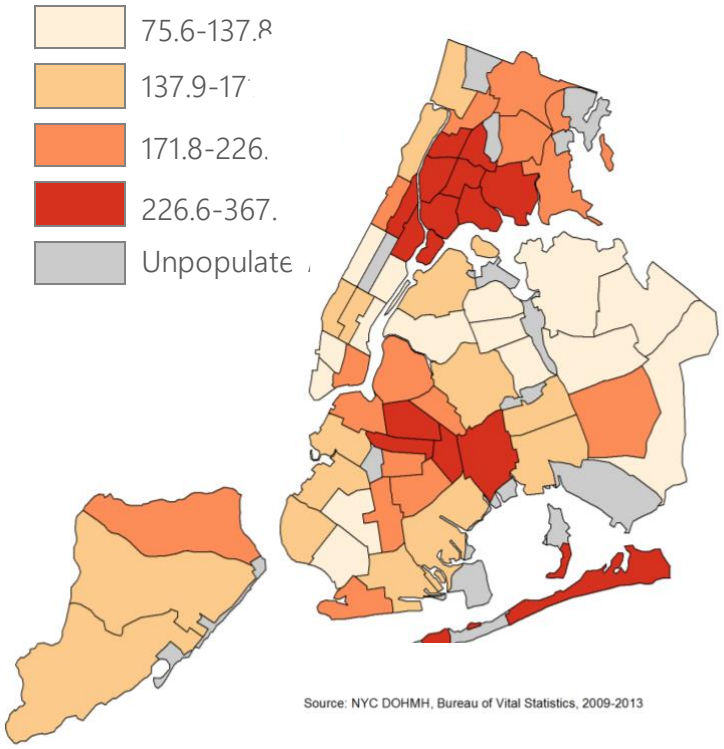
Source: HealthBegins 2020. 1. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on social determinants of health. Final Report. Geneva. World Health Organization (CHE); 2008.

Across Neighborhoods

PEOPLE ARE DYING TOO EARLY

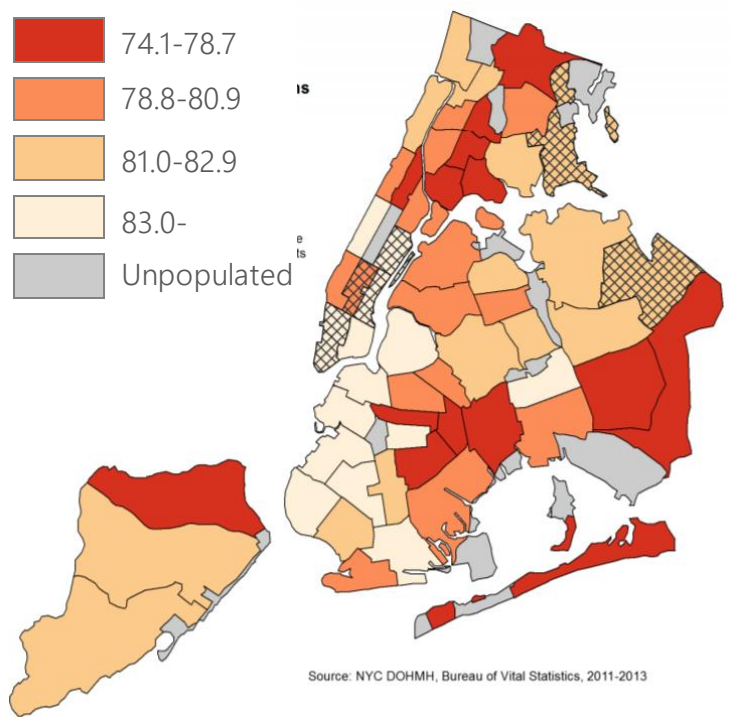
Premature Mortality (death before age 65)

Rate per 100,00 population



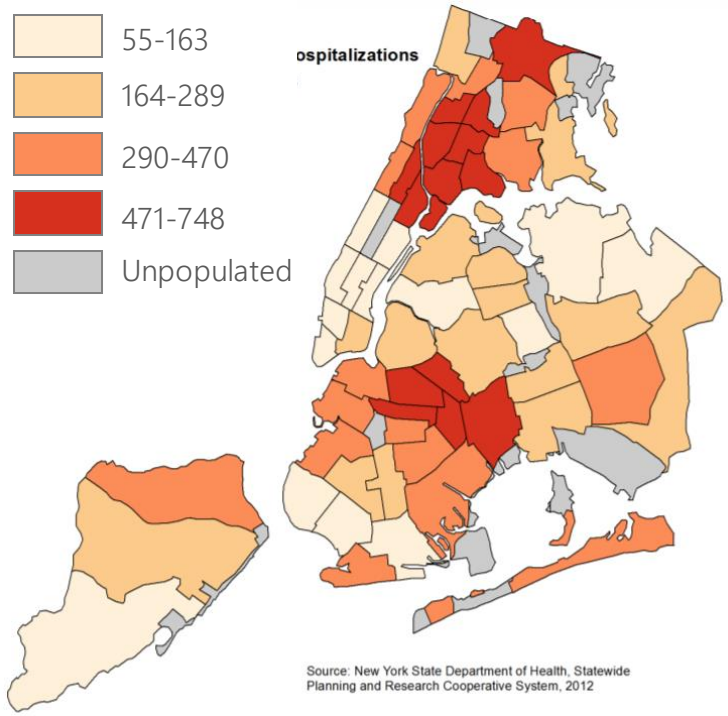
Life Expectancy

Years



Avoidable Adult Diabetes Hospitalizations

Rate per 100,00 adults



Source: NYC Dept. Health: Community Health Profiles — 2015 Atlas

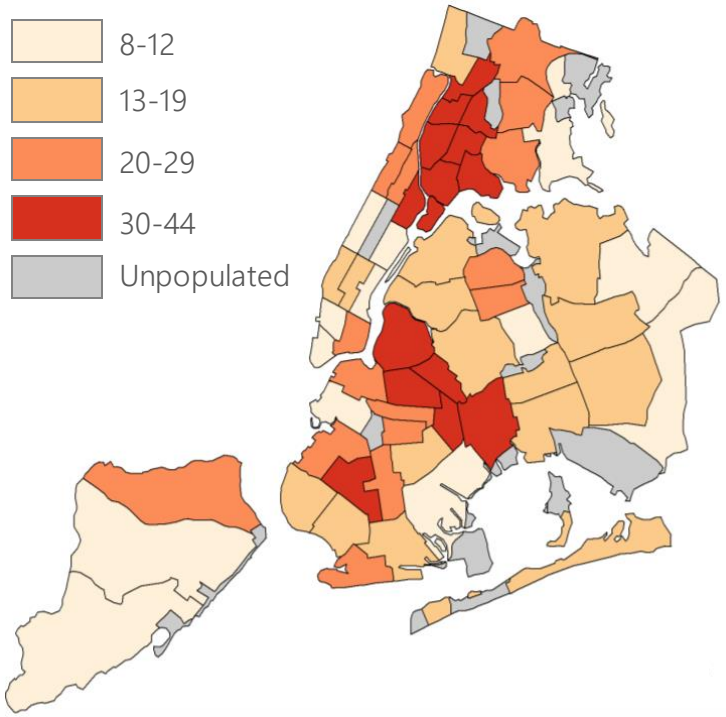
AMA | Physicians' powerful ally in patient care

Across Neighborhoods

DIFFERENCES IN SOCIAL CONDITIONS

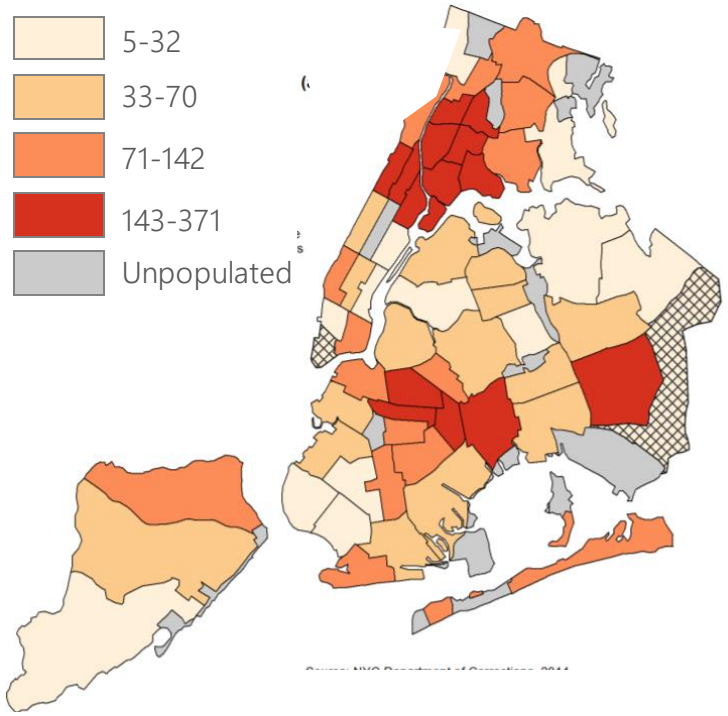
Poverty

Percent below federal poverty level



Jail Incarceration

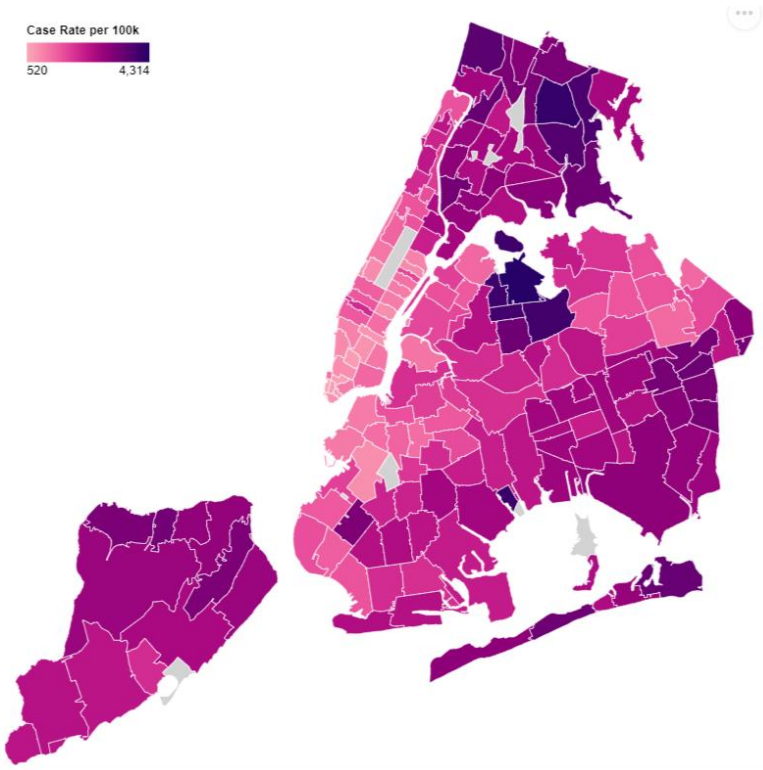
Rate per 100,00 adults (ages 16+)



Source: NYC Dept. Health: Community Health Profiles — 2015 Atlas

COVID Case Rate

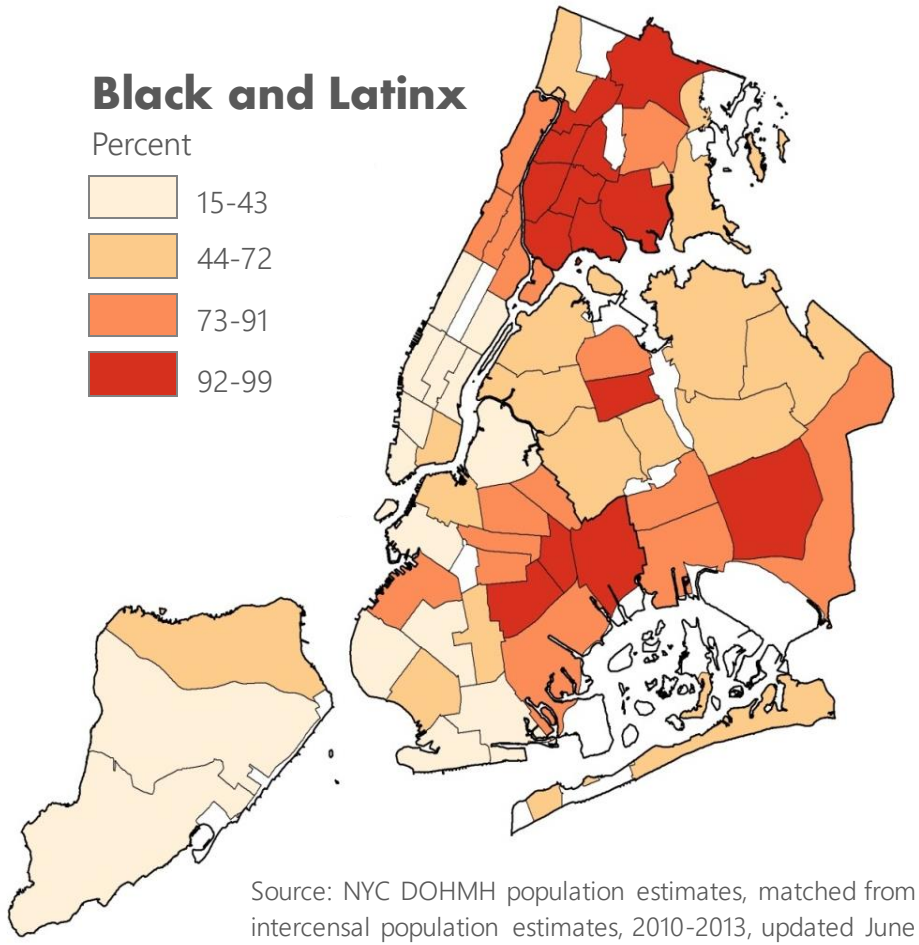
Rate per 100,00 adults (ages 16+)



Source: https://www1.nyc.gov/site/doh/covid/covid-19-data.page

Across Neighborhoods

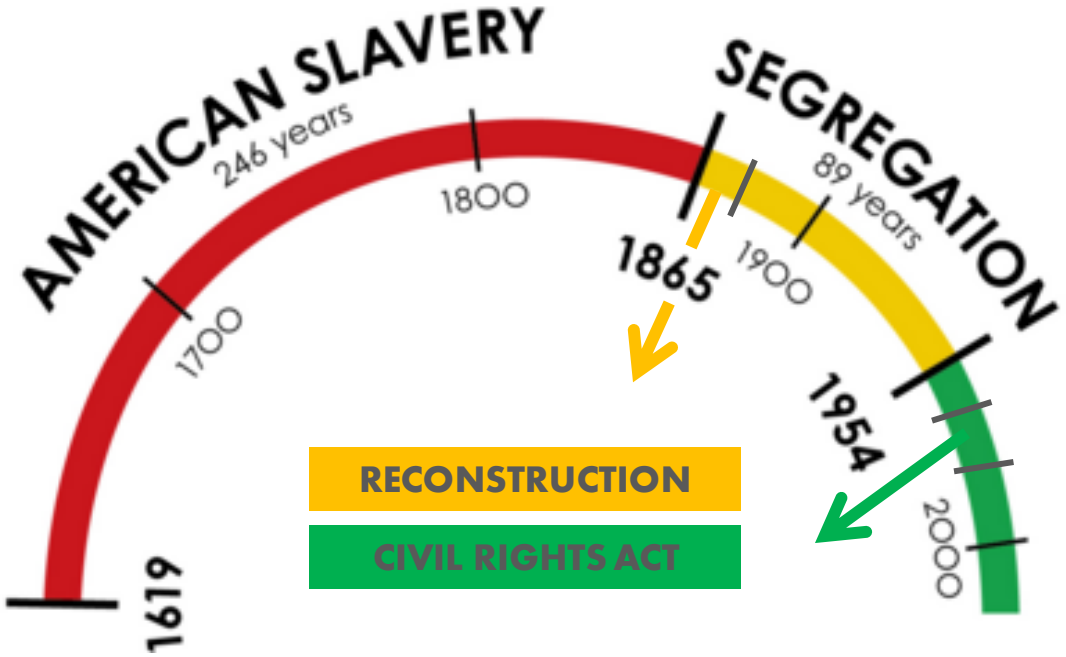
SEGREGATION BY RACE

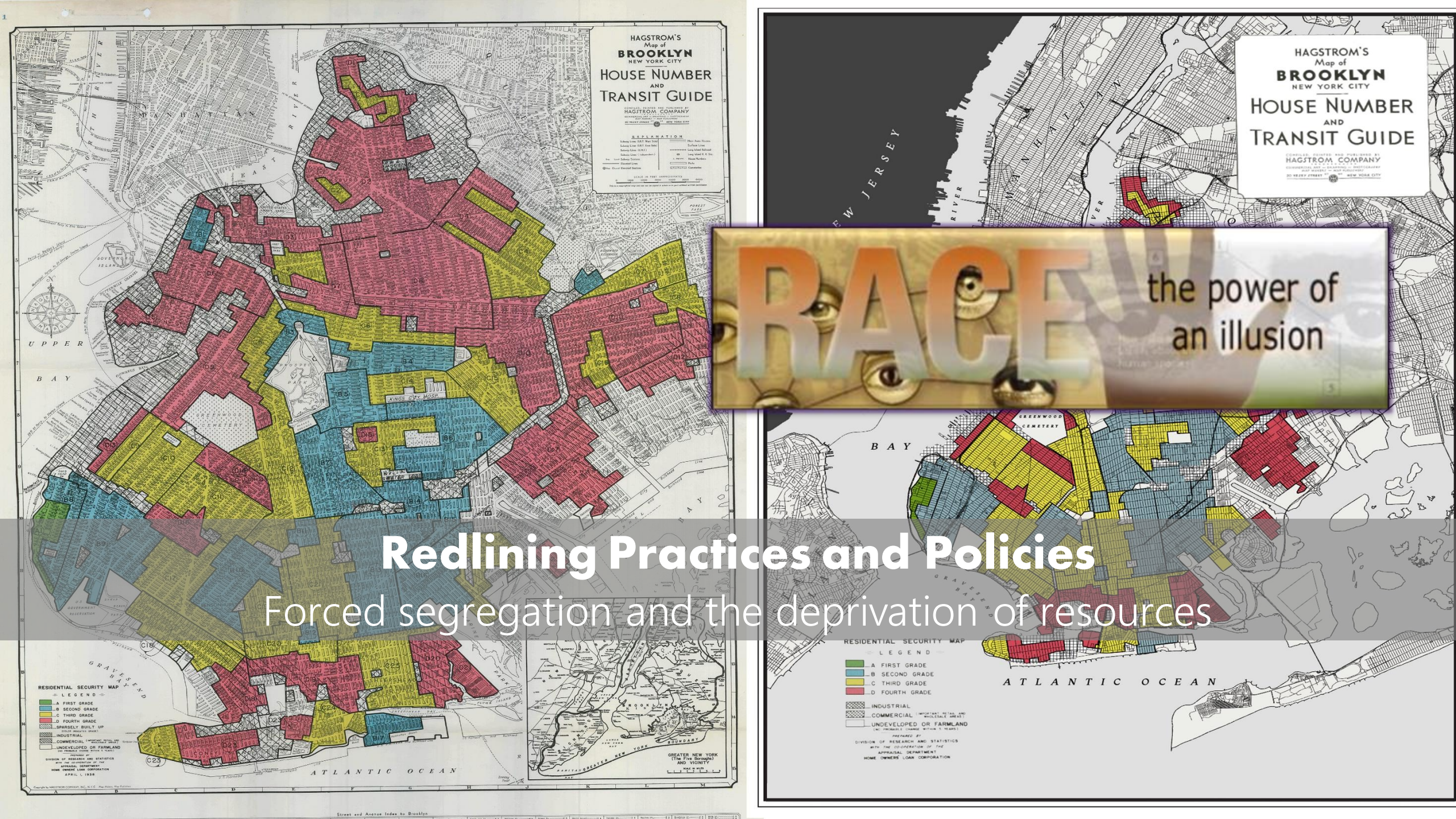


Source: NYC DOHMH population estimates, matched from US Census Bureau intercensal population estimates, 2010-2013, updated June 2014
U.S. Census Bureau; American Community Survey, 2013 3-year Estimates, Table S1701; generated using American Fact Finder (http://factfinder2.census.gov/)

Racism is a System of power and oppression that structures opportunities and assigns value based on race, unfairly disadvantaging people of color (racial oppression), while unfairly advantaging Whites (racial privilege & supremacy)

-**Internalized-Interpersonal-Institutional-Structural**





Redlining Practices and Policies

Forced segregation and the deprivation of resources

America: Equity and Equality in Health 3

Structural racism and health inequities in the USA: evidence and interventions

Zinzi D Bailey, Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, Mary T Bassett

Despite growing interest in understanding how social factors drive poor health outcomes, many academics, policy makers, scientists, elected officials, journalists, and others responsible for defining and responding to the public discourse remain reluctant to identify racism as a root cause of racial health inequities. In this conceptual report, the third in a Series on equity and equality in health in the USA, we use a contemporary and historical perspective to discuss research and interventions that grapple with the implications of what is known as structural racism on population health and health inequities. Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources. We argue that a focus on structural racism offers a concrete, feasible, and promising approach towards advancing health equity and improving population health.

Introduction

Racial and ethnic inequalities, including health inequities, are well documented in the USA (table),[1–5] and have been a part of government statistics since the founding of colonial America.[6–8] However, controversies abound over explanations for these inequities.[6–8] In this report, we offer a perspective not often found in the medical literature or taught to students of health sciences, by focusing on structural racism (panel 1)[9–11] as a key determinant of population health.[9,10,12,13] To explore this determinant of health and health equity, we examine a range of disciplines and sectors, including but not limited to medicine, public health, housing, and human view—one that identifies and seeks to alter how such racism contributes to poor health—is required to understand, prevent, and address the harms related to structural racism. There is a rich social science literature conceptualising structural racism,[8–10,19] but this research has not been adequately integrated into medical and scientific literature geared towards clinicians and other health professionals.[9,10,12,13] In this report, we examine what constitutes structural racism, explore evidence of how it harms health, and provide examples of interventions that can reduce its impact. Our central argument is that a focus on structural racism is essential to advance health equity and improve population health.

Lancet 2017; 389: 1453–63

See Editorial page 1369

See Comment pages 1376 and 1378

This is the third in a Series of five papers about equity and equality in health in the USA

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See Online for infographic www.thelancet.com/

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Case Studies in Social Medicine — Attending to Structural Forces in Clinical Practice

Scott D. Stonington, M.D., Ph.D., Seth M. Holmes, Ph.D., M.D., Helena Hansen, M.D., Ph.D., Jeremy A. Greene, M.D., Ph.D., Keith A. Wailoo, Ph.D., Debra Malina, Ph.D., Stephen Morrissey, Ph.D., Paul E. Farmer, M.D., Ph.D., and Michael G. Marmot, M.B., B.S., Ph.D.

Many clinicians and trainees see the social world as a messy, impenetrable black box: they may acknowledge its influence on their patients' health, but they lack the understanding and tools for incorporating it usefully into their diagnostic reasoning and therapeutic interventions. But the social sciences of health and medicine provide such tools — theories and methods for understanding social processes and intervening to effect change. Leading organizations in medical education have recommended providing additional training in social medicine, which deploys these approaches to improve health.[1,2] In this issue, the *Journal* launches Case Studies in Social Medicine, a series of Perspective articles, to highlight the importance of social concepts and social context in clinical medicine. The series will use discussions of real clinical cases to translate these tools into terms that can readily be used in medical education, clinical practice, and health system planning.

In their first year in medical school, all students learn to take a social history. As they transform their eyes, ears, and hands into sensors for detect-

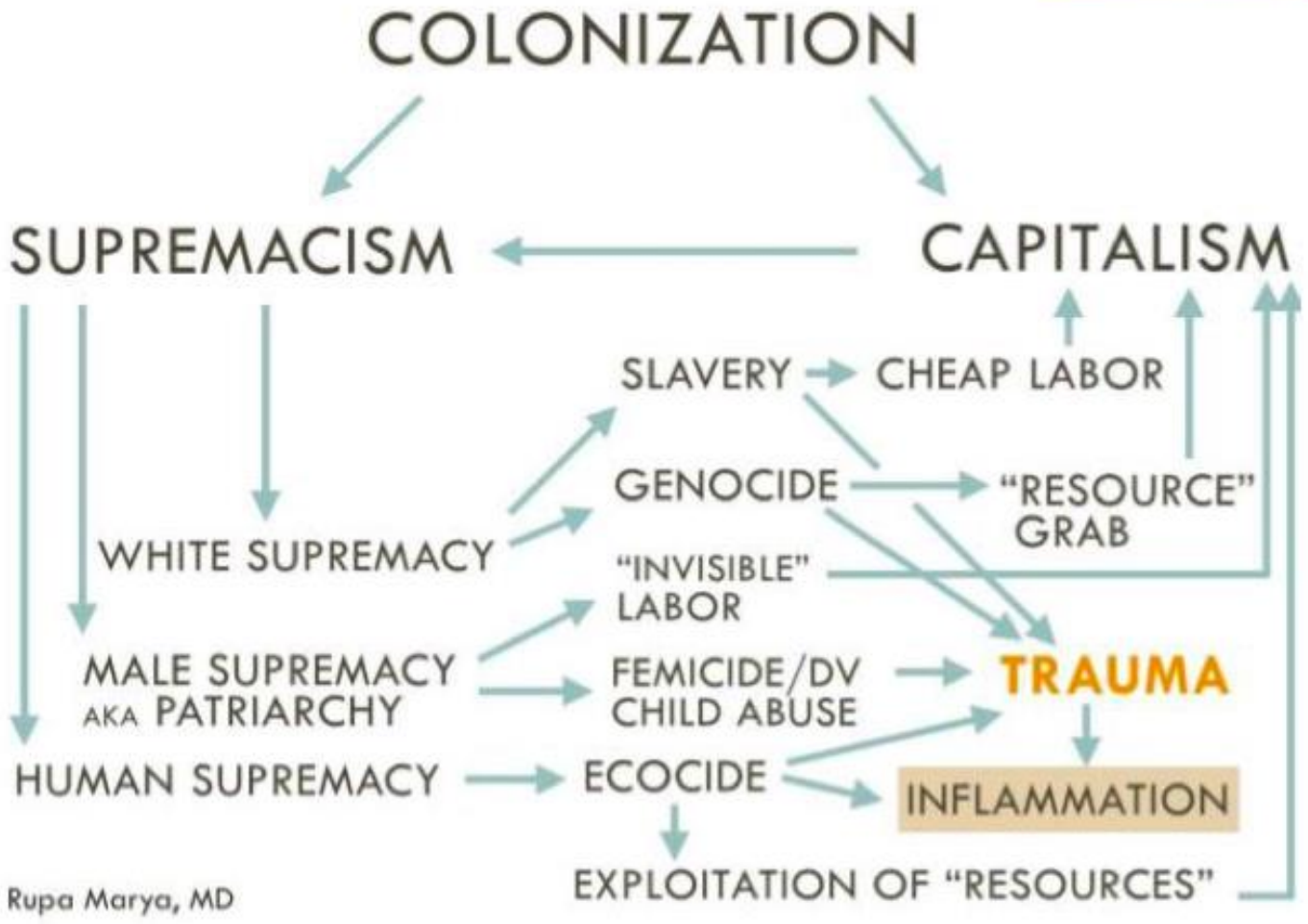
in clinical medicine, the biologic and behavioral world of a patient's body is more important than the social world outside it.

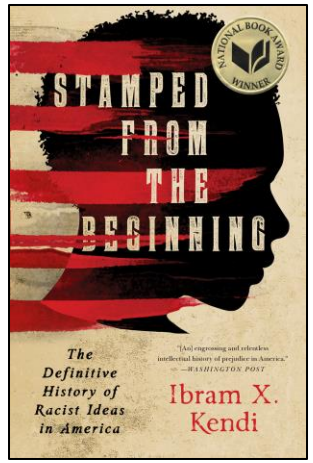
This erasure flies in the face of increasing evidence documenting the role of social forces in determining health, disease, treatment, and recovery. Noncommunicable diseases, including coronary heart disease, stroke, lung cancer, chronic obstructive pulmonary disease, and mental health disorders, remain major global causes of illness and death, and their prevalence is increasing.[3] The likelihood that these conditions and the prognoses and treatment outcomes associated with them will develop are strongly predicted by social factors, including income, race, ethnicity, immigration status, and place of residence: they cluster in social networks and are exacerbated by social inequalities.[4] The fundamental causes of health and disease, however, are not these seemingly static characteristics that mark inequalities, but rather the social, political, and economic forces that drive these inequalities in the first place — what we would call the structural determinants of the

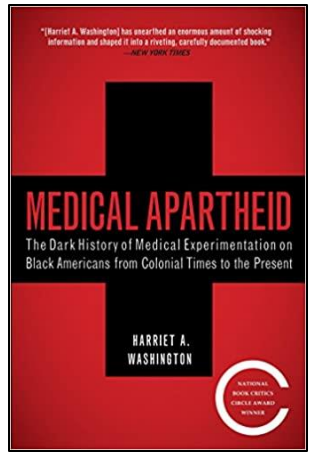
Structural Violence

"Johan Galtung introduced the term "structural violence" in 1969 to explain the process by which social institutions caused harm to individuals or groups by preventing them from reaching their potential or by depriving them of the resources they need to survive."

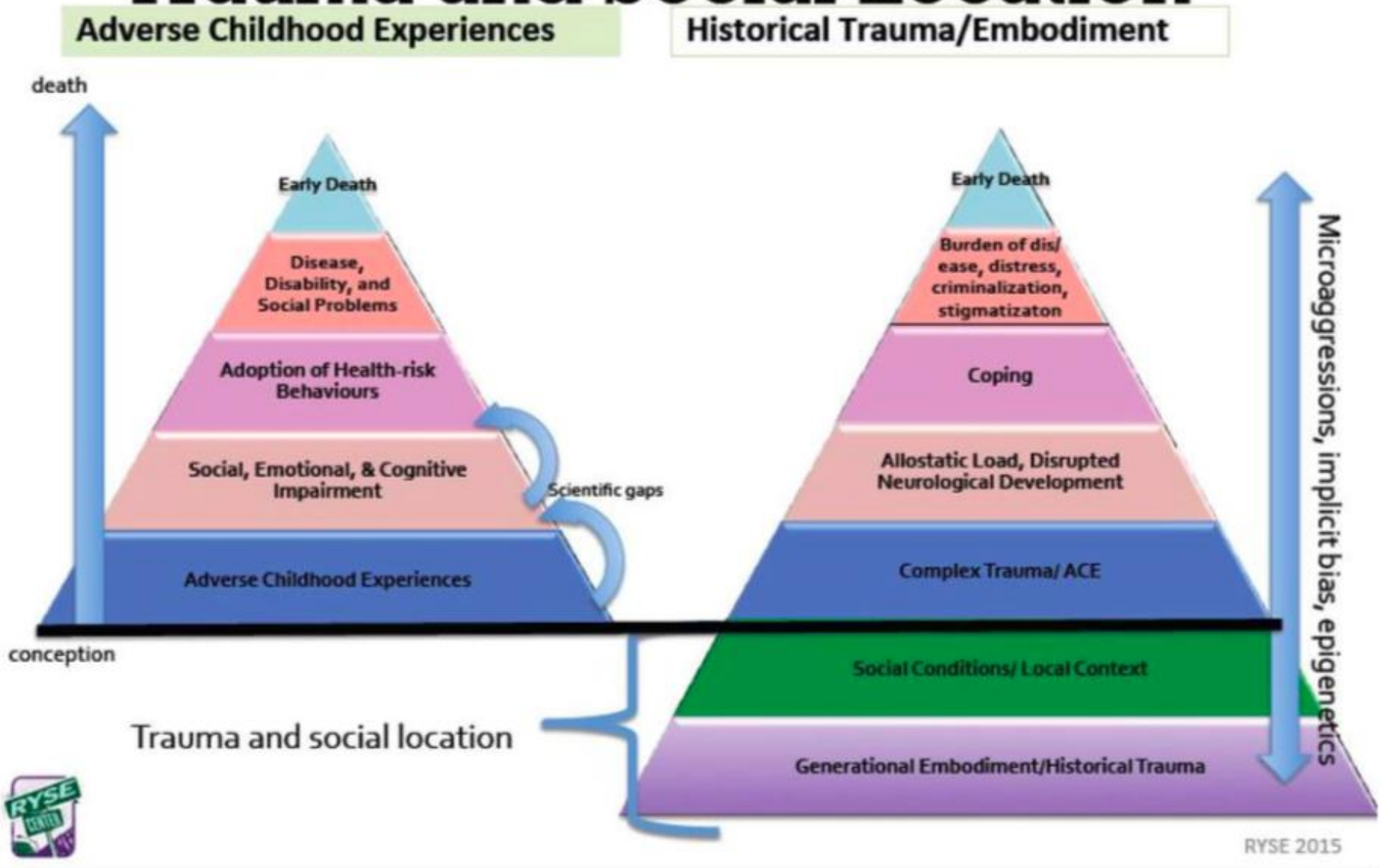
"To understand the root causes of the pathologies we see today, which impact all of us but affect Brown, Black and Poor people more intensely, we have to examine the foundations of this society which began with COLONIZATION…. Colonization was the way the extractive economic system of Capitalism came to this land, supported by systems of supremacy and domination which are a necessary part to keep wealth and power accumulated in the hands of the colonizers and ultimately their financiers." — Dr. Rupa Marya





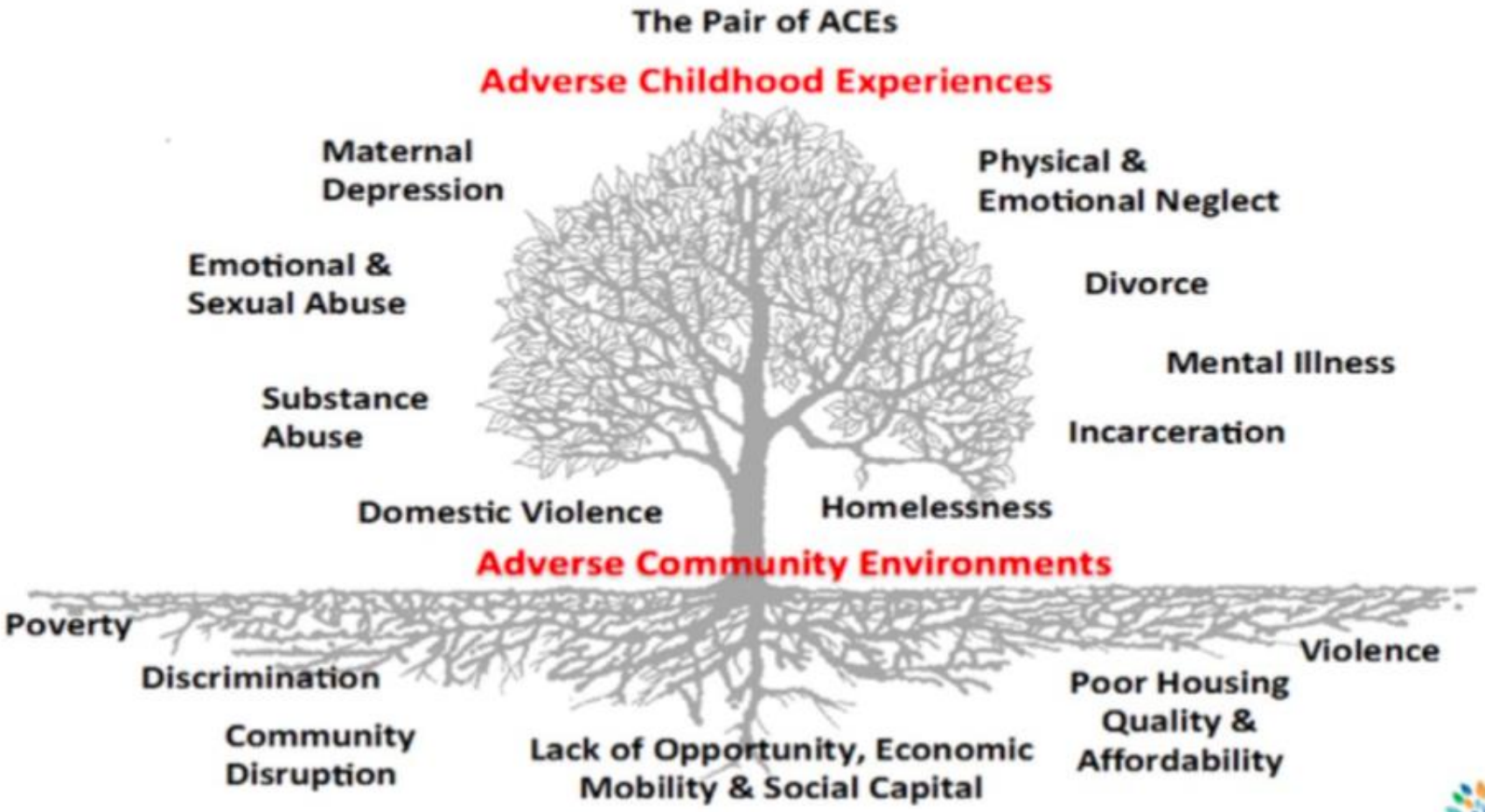


Trauma and Social Location



8 of the 10 Leading causes of death linked to early traumatic exposure…

As are over 40 health conditions



Ellis W., Dietz W. BCR Framework *Academic Peds* (2017)

Milken Institute School of Public Health

Building Community Resilience

Participants who suffered <u>three</u> or more adverse childhood experiences had much higher rates of:

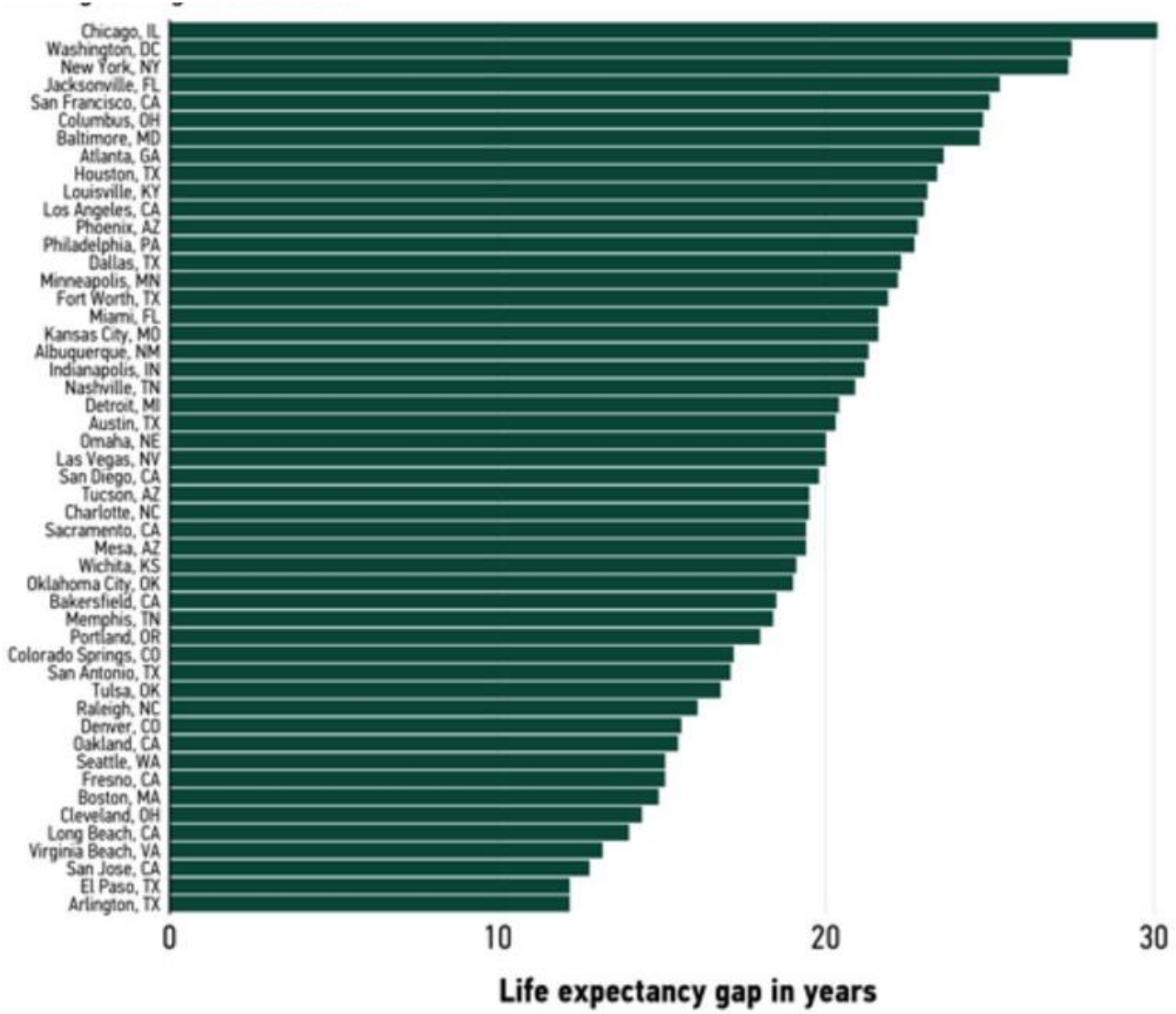
Substance abuse
Domestic violence
Suicide attempts

Were more likely to have:

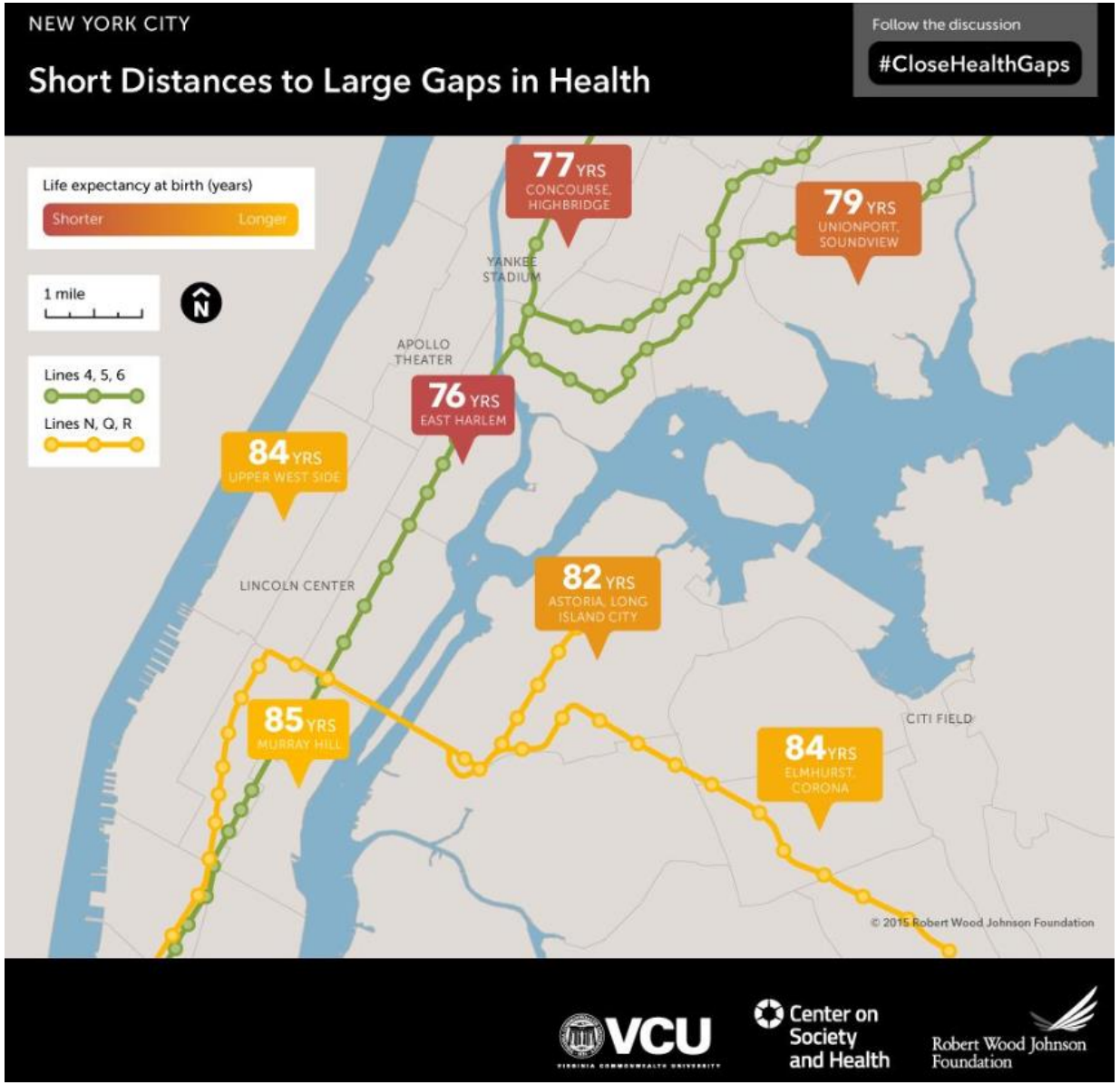
Dropped out of school
Divorced
Diabetes
Obesity
Cancer
Heart disease

Life expectancy gaps between neighborhoods among the 50 largest cities in the US

> 30 years in Chicago
> 20 years in 25 cities



Source: NYC School of Medicine



Blacks, Latinx, and Native Americans are more likely to have and die from ‘underlying conditions’:

Higher rates of

- Diabetes
- Obesity
- Hypertension
- Heart Disease

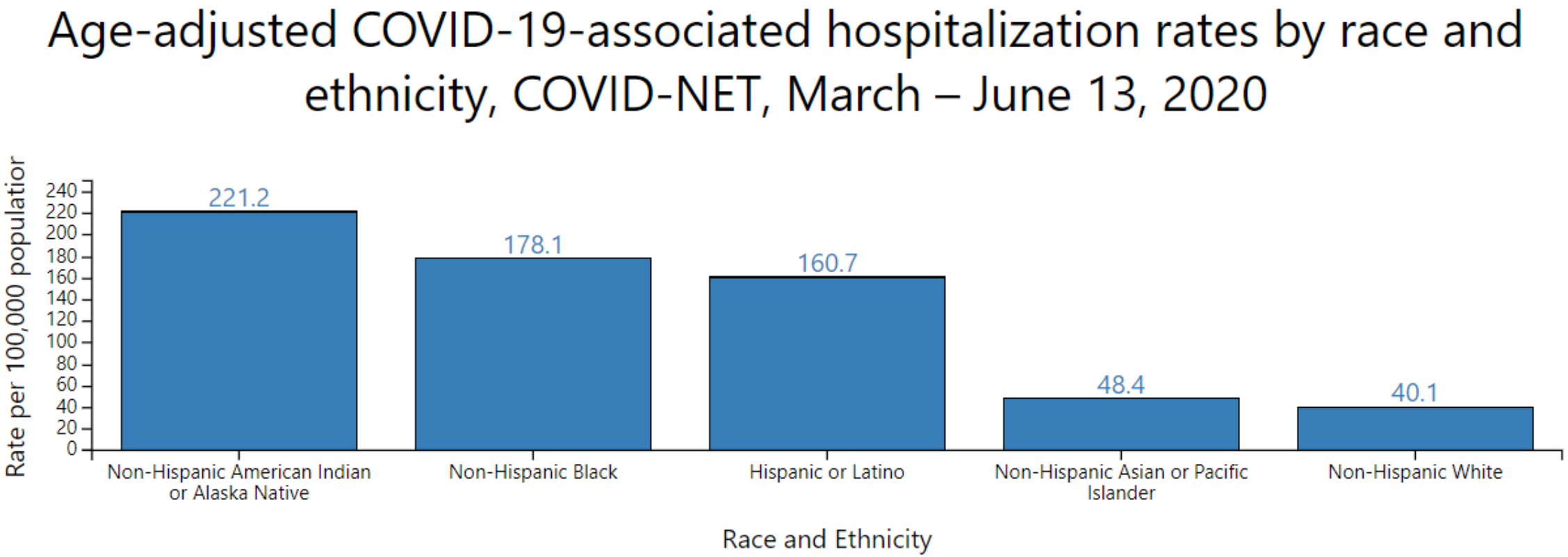
…and at younger ages

Must first look to…

- Greater experience with the structural and social drivers (underlying conditions) of health inequities creates greater EXPOSURE
- More likely to have service jobs; low wealth, consistent and affordable housing; overcrowding housing (hard to shelter in place); lack of running water (NA)
- Lack of quality and consistent healthcare (varies regionally); lack of trust for healthcare
- Higher rates of incarceration (often for minor, non-violent offenses)

Black people are not to blame for COVID-19. Black people are not a risk factor. “Race is not a risk factor…Racism is.” @DrJoiaCrearPerry

Blacks, Latinx, and Native Americans have highest rates of COVID-19 hospitalizations



Dominant narratives, embedded in our institutions and culture, represent voices reinforcing social relations that generate social, political, and economic inequality and racial injustice marginalizing or silencing the voices of social groups with limited power. These narratives shape consciousness, meaning, and explanations of events.

Narrative

Their effect is to **obscure power (and responsibility)**, divide populations with common concerns, enforce compliance, and ensure that opposing visions of society's future do not become reality.

Power and privilege

“In my class and place, I did not recognize myself as a racist because I was taught to see racism only in individual acts of meanness by members of my group, never in invisible systems conferring unsought racial dominance on my group from birth.”

"For me, white privilege has turned out to be an elusive and fugitive subject. The pressure to avoid it is great, for in facing it I must give up the myth of meritocracy. If these things are true, this is not such a free country; one's life is not what one makes it; many doors open for certain people through no virtues of their own."

Peggy McIntosh, 1988
White Privilege:
Unpacking the Invisible Knapsack

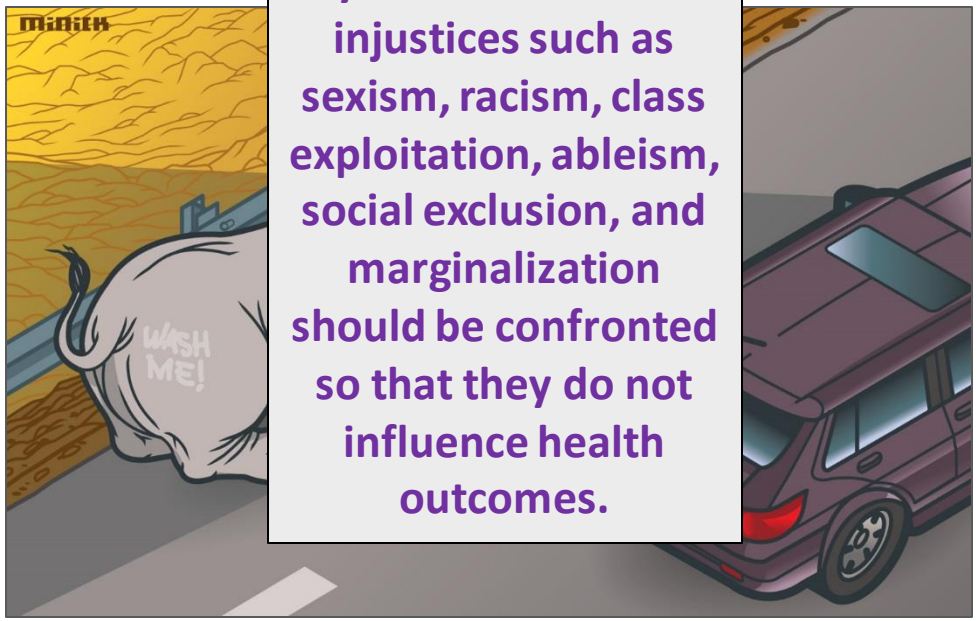
Bias and blindspots

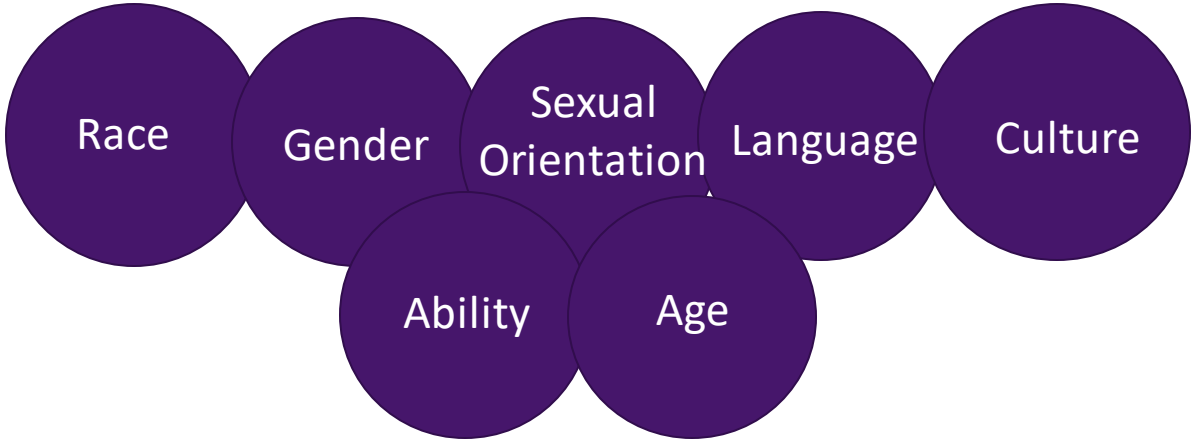
"All of us, despite the best of all possible intentions, are affected by unconscious processes. It affects what we see, how we react, how we feel, how we behave. If we're not aware of it and taking measures to counter it, it affects quality of care."

- Michelle van Ryn, Ph.D.

Director of Mayo's Research Program on Equity and Inclusion in Health Care

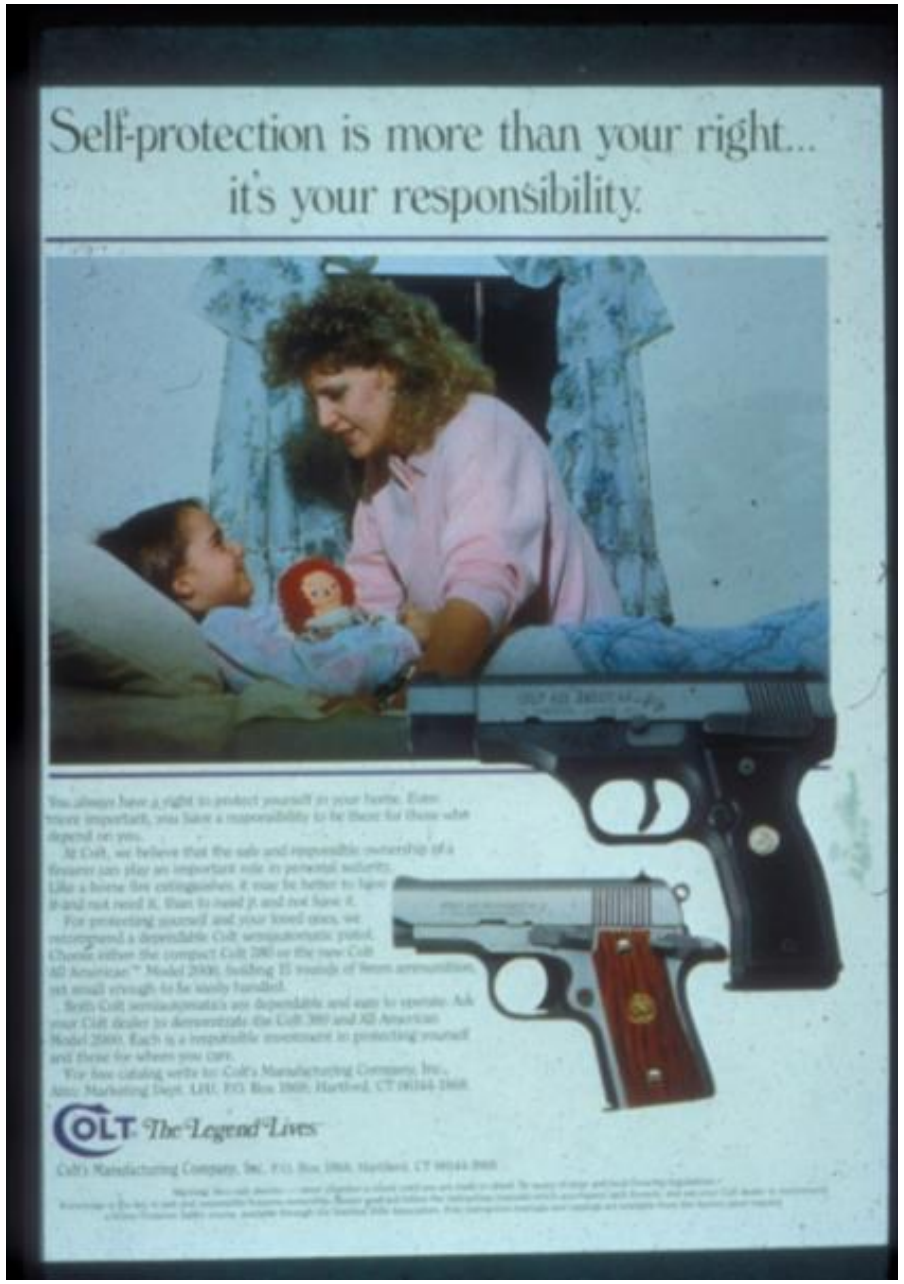
Reframe:
Systemic and social injustices such as sexism, racism, class exploitation, ableism, social exclusion, and marginalization should be confronted so that they do not influence health outcomes.



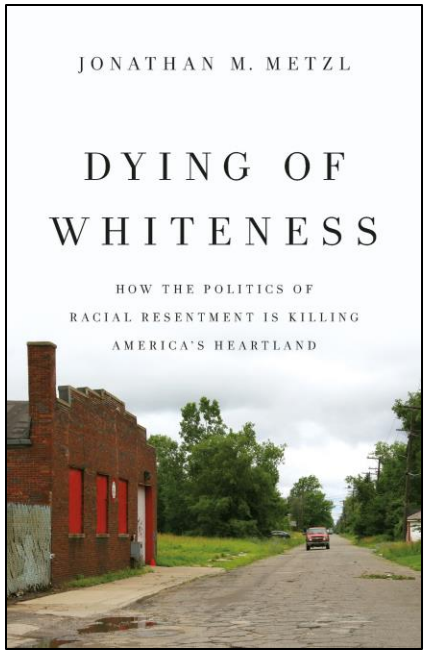


Narrative shapes beliefs …dominant narratives (myths) undermine health equity

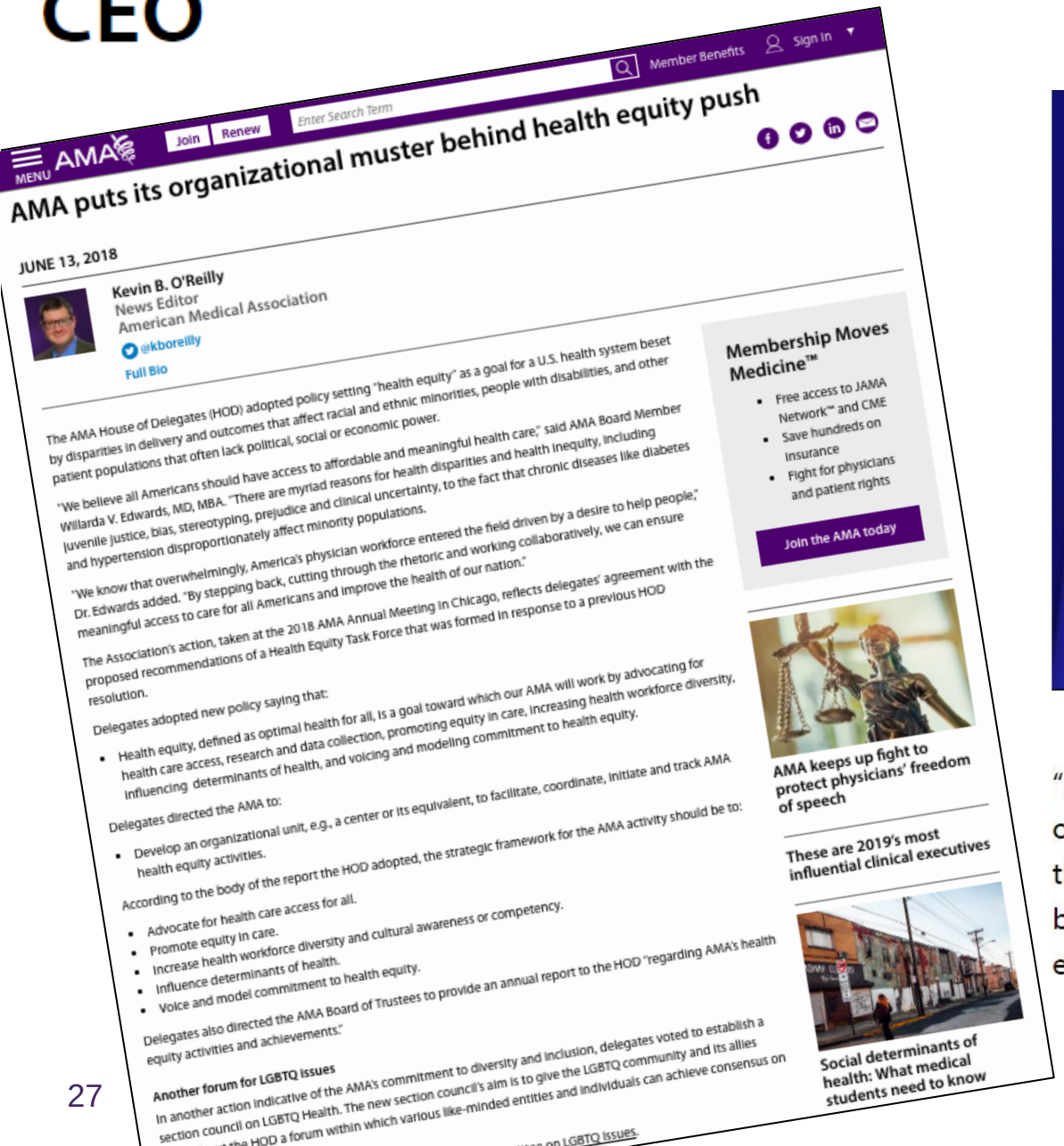
- Racial and class inequities are “unfortunate, but not necessarily unjust”
- Self-determining individuals make right or wrong “lifestyle” choices (Rendering political, structural, and social determinants of health inequities invisible)
- Cultures of oppressed and marginalized racial and ethnic groups are responsible for and blamed their own poorer health outcomes (“Othering”)
- Pick ourselves by our bootstraps (meritocracy)
- American exceptionalism
- “If you gain, I lose” (zero-sum game)
- Hierarchy of human value based on skin color (White supremacy)



" Why would someone reject their own health care, or keep guns-unlocked when their children were home? Yet because of the frames cast around these and other issues hued with historically charged assumptions about privilege, it became ever-more difficult for people with whom I spoke to imagine alternate realities or emphasize with groups (racial) other than their own. Compromise, in many ways, coded as treason."



21st century medicine must tackle health inequity: AMA CEO



MENU AMA Join Renew Enter Search Term Member Benefits Sign In

AMA puts its organizational muster behind health equity push

JUNE 13, 2018

Kevin B. O'Reilly
News Editor
American Medical Association
@kboreilly
Full Bio

The AMA House of Delegates (HOD) adopted policy setting "health equity" as a goal for a U.S. health system beset by disparities in delivery and outcomes that affect racial and ethnic minorities, people with disabilities, and other patient populations that often lack political, social or economic power.

"We believe all Americans should have access to affordable and meaningful health care," said AMA Board Member Willarda V. Edwards, MD, MBA. "There are myriad reasons for health disparities and health inequity, including juvenile justice, bias, stereotyping, prejudice and clinical uncertainty, to the fact that chronic diseases like diabetes and hypertension disproportionately affect minority populations.

"We know that overwhelmingly, America's physician workforce entered the field driven by a desire to help people," Dr. Edwards added. "By stepping back, cutting through the rhetoric and working collaboratively, we can ensure meaningful access to care for all Americans and improve the health of our nation."

The Association's action, taken at the 2018 AMA Annual Meeting in Chicago, reflects delegates' agreement with the proposed recommendations of a Health Equity Task Force that was formed in response to a previous HOD resolution.

Delegates adopted new policy saying that:

- Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research and data collection, promoting equity in care, increasing health workforce diversity, influencing determinants of health, and voicing and modeling commitment to health equity.

Delegates directed the AMA to:

- Develop an organizational unit, e.g., a center or its equivalent, to facilitate, coordinate, initiate and track AMA health equity activities.

According to the body of the report the HOD adopted, the strategic framework for the AMA activity should be to:

- Advocate for health care access for all.
- Promote equity in care.
- Increase health workforce diversity and cultural awareness or competency.
- Influence determinants of health.
- Voice and model commitment to health equity.

Delegates also directed the AMA Board of Trustees to provide an annual report to the HOD "regarding AMA's health equity activities and achievements."

Another forum for LGBTQ issues

In another action indicative of the AMA's commitment to diversity and inclusion, delegates voted to establish a section council on LGBTQ Health. The new section council's aim is to give the LGBTQ community and its allies the HOD a forum within which various like-minded entities and individuals can achieve consensus on

on LGBTQ issues.

Membership Moves Medicine™

- Free access to JAMA Network™ and CME
- Save hundreds on insurance
- Fight for physicians and patient rights

Join the AMA today

AMA keeps up fight to protect physicians' freedom of speech

These are 2019's most influential clinical executives

Social determinants of health: What medical students need to know

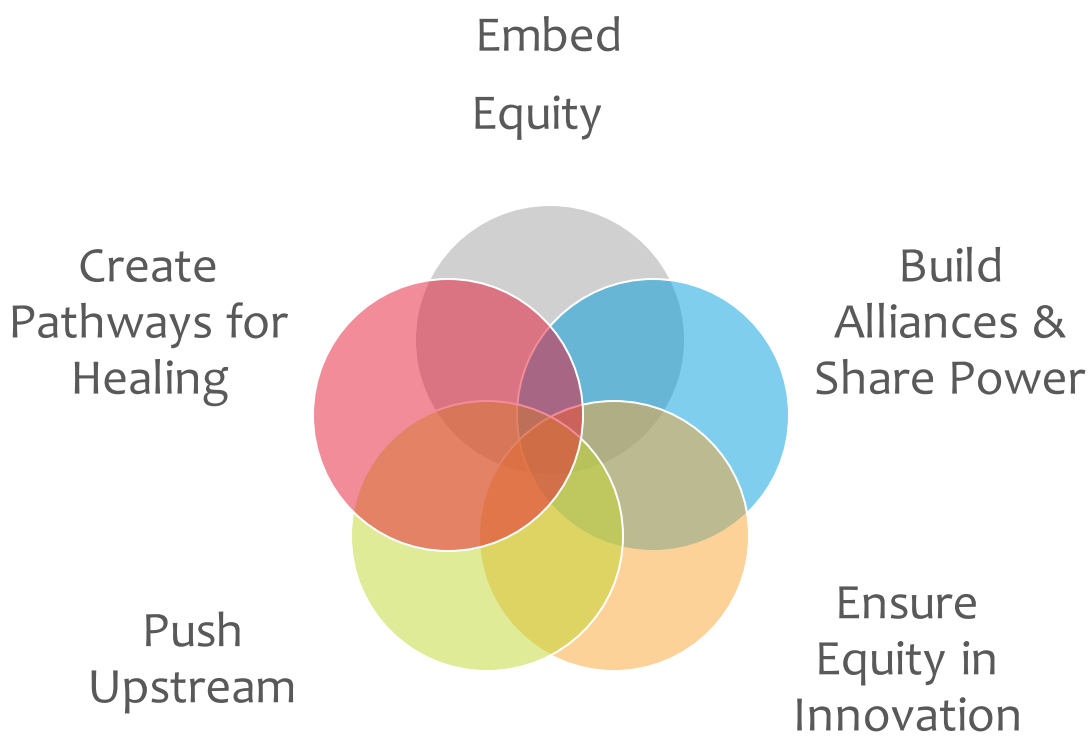
"What has become clear is that the inequities that persist throughout health care present obstacles to achieving our goals," he said. "As a nation, and as an association, we need to ensure that when solutions to improve health care are identified, that positive impacts are recognized by all—that one shared characteristic of such solutions is that they also bend toward health equity."

Center for Health Equity

Vision: A nation where all people live in thriving communities where resources work well, systems are equitable and create no harm, and everyone has the power to achieve optimal health; and all physicians are equipped with the consciousness, tools, and resources to confront inequities as well as embed and advance equity within and across all aspects of the healthcare system.

Mission: Strengthen, amplify, and sustain the AMA's work to eliminate health inequities – improving health outcomes and closing disparities gaps – which are rooted in historical and contemporary injustices and discrimination.

Strategic Approaches



- **Embed health equity** in practice, process, action, innovation and organizational performance and outcomes
- **Build alliances and share power** via meaningful engagement
- **Ensure equitable** opportunities and conditions in **innovation** for marginalized and minoritized people and communities
- **Push upstream** to address all determinants of health
- **Create pathways** for truth, **reconciliation**, and healing

2020

The AMA's Strategic Work

Leading the charge to confront chronic disease and public health crises

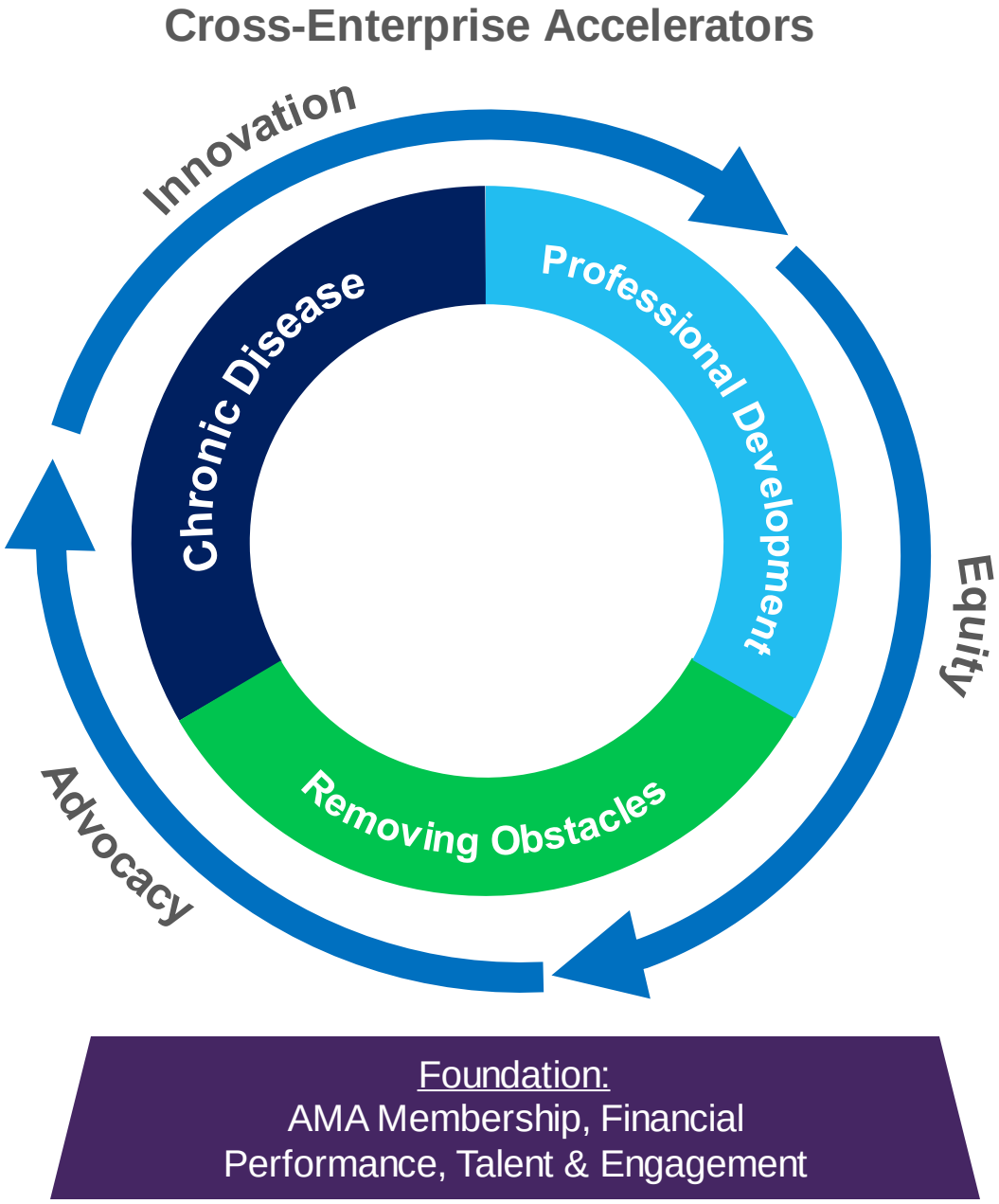
- *Helping Americans achieve no new preventable cases of Type 2 Diabetes, all adults meeting their blood pressure goals, and an end to the opioid epidemic*

Driving the future of medicine

- *Reimagining training, education, and lifelong learning and promoting innovation to tackle the biggest challenges in health care*

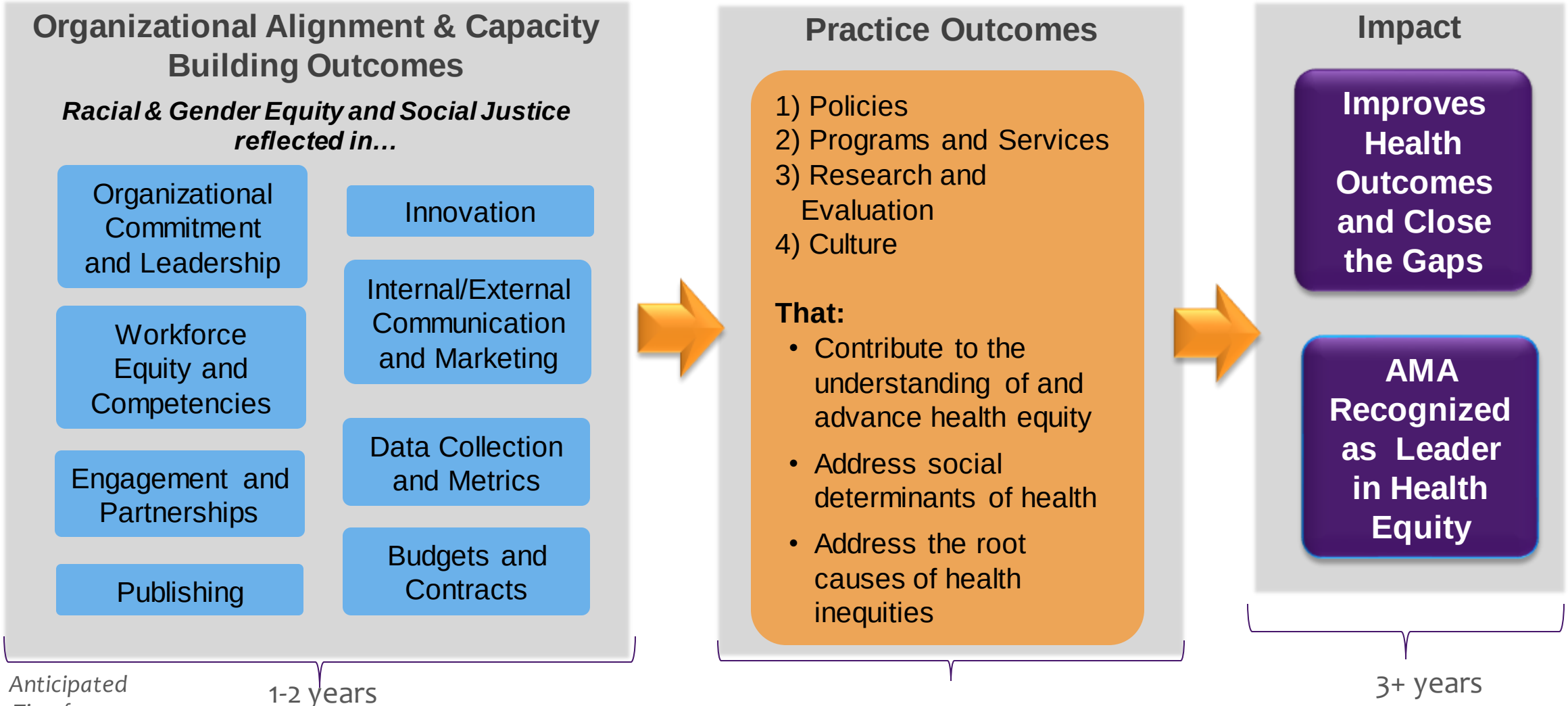
Removing obstacles that interfere with patient care

- *Making the patient-physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past*



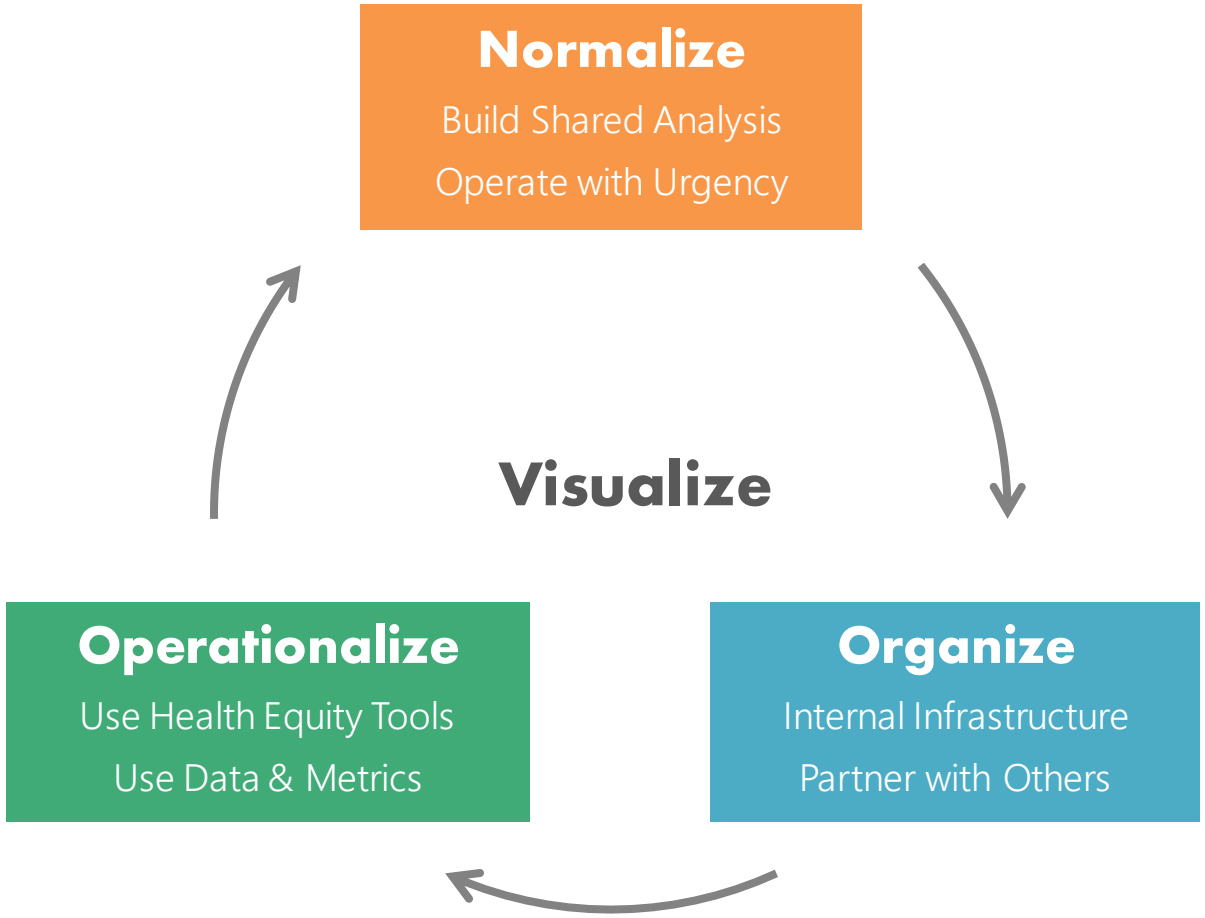
Theory of Change

Building Organizational Capacity to Reduce Inequities and Advance Structural Change



Transform (Impact Model – Inside Strategy)

Addressing practice and culture within our institution



National Best Practice
From RaceForward/Center for Social Inclusion and Government Alliance on Race and Equity (GARE)

Normalize

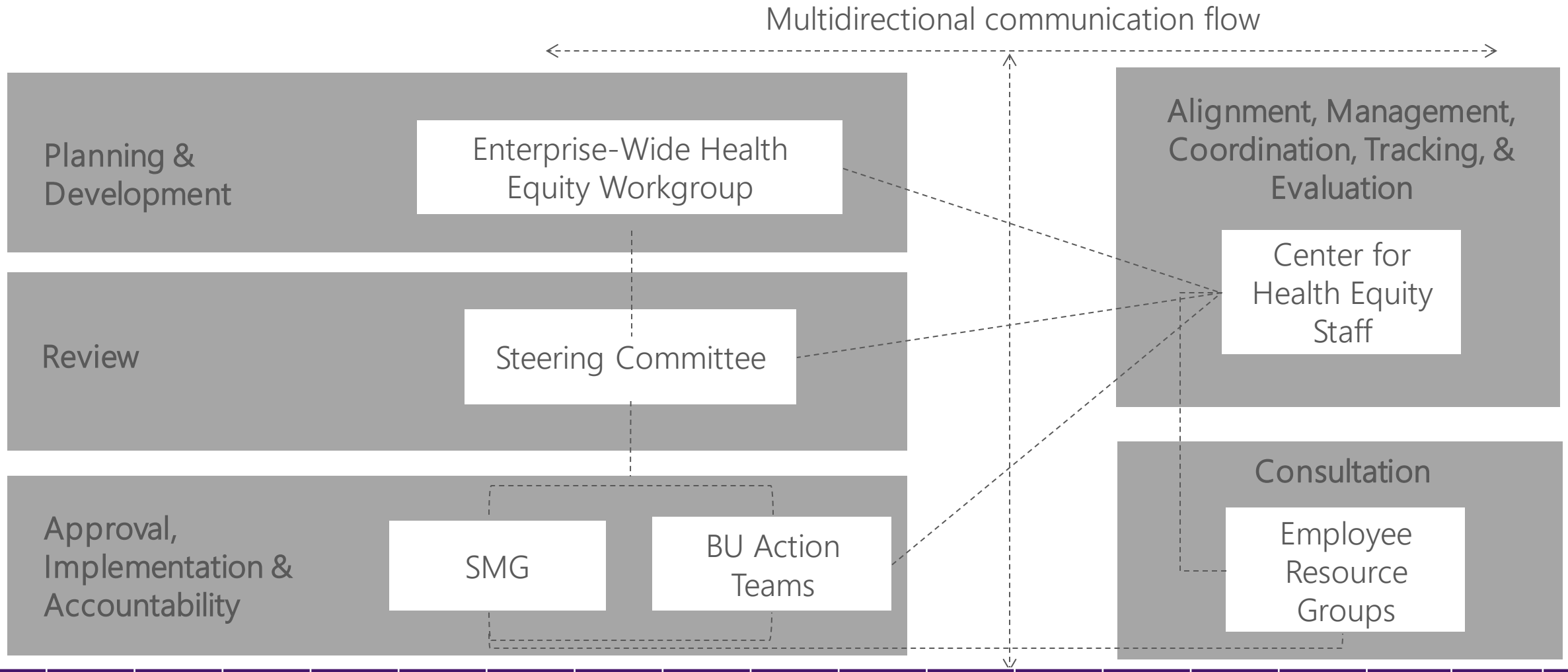
REI
racialequityinstitute, llc

"As part of AMA's health equity journey, I encourage all staff to take full advantage of these training opportunities over the coming years. I ask that supervisors consider the importance of this training to the overarching goals of the AMA and support representation of their BU at the scheduled trainings.

The health equity imperative is integral to the success of all of AMA's work and requires commitment. The greatest demonstration of this commitment is our active participation as leadership."

– Jim Madara, October 2019

Organize



ADV	EBO	PUB / EDH	EC	EI/M R	FIN	H&S	HSG	HR	IHO	IT	IHMI	JAMA	MMX	MED ED	OGC	PS2	AMAF	AMAI

Operationalize

How do we ensure our efforts and innovation do not discriminate, exacerbate inequities, or deny care?

What's the data? What does the data tell us? What data are missing?

How have communities (physicians, patients, etc.) been engaged?
Are there opportunities to expand engagement?

Who benefits from or will be burdened by your proposal?
What are your strategies for advancing equity or mitigating unintended consequences?

Who holds the decision-making power and privilege?
Are there opportunities to share/shift power?

How will you ensure accountability to communicate, and evaluate results?

Adapted from the Racial Equity Toolkit: An Opportunity to Operationalize Equity – Gov't Alliance on Race and Equity

Operationalizing Equity during COVID-19

Lase Ajayi, MD
Member since 2013

JAMA Article

VIEWPOINT

Responding to the COVID-19 Pandemic
The Need for a Structurally Competent Health Care System

Jonathan M. Metzl, MD, PhD
Department of Medicine, Health, and Society, Vanderbilt University, Nashville, Tennessee.

Aletha Maybank, MD, MPH
Chief Health Equity Officer, American Medical Association, Chicago, Illinois.

Fernando De Maio, PhD
Center for Health Equity, American Medical Association, Chicago, Illinois; and Department of Sociology, DePaul University, Chicago, Illinois.

The coronavirus disease 2019 (COVID-19) pandemic has exposed the consequences of inequality in the US. Even though all US residents are likely equally susceptible to infection with SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), the virus that causes COVID-19 disease, the resulting illness and the distribution of deaths reinforces systems of discriminatory housing, education, employment, earnings, health care, and criminal justice.[1,2] The patterns of COVID-19 illuminate centuries of support systems that the US did not build and investments it did not make.

Each stage of the pandemic, from containment, to mitigation, to reopening, highlights the extent to which certain populations were rendered vulnerable long before the virus arrived. As a result, marginalized, minoritized, and communities of low wealth have been at highest risk, with disproportionate death rates among African American, Latinx, and Native American populations across the US.[3,4]

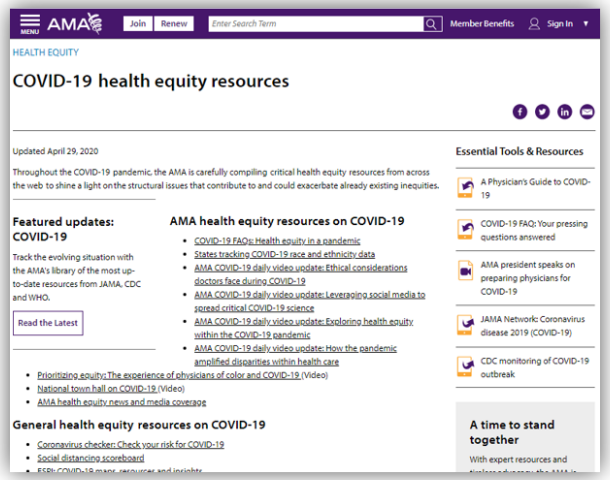
Sociodemographic differences in COVID-19 morbidity and mortality highlight an unavoidable reality facing the US health care system as it strives to fulfill its mission to promote health and well-being, and to treat disease. At its core, the practice of medicine is based on individual-level interactions among clinicians, patients, and families. Yet the pandemic highlights the extent to which illness for many people results from larger structures, systems, and economies.[1,2] harmful social conditions that fundamentally shape pandemic patterns.[6]

Over the coming months and years, the US health care system will struggle to adapt to new, postpandemic norms. In this moment of crisis, however, the US health care system has a generational imperative to begin to address the inequities made even more apparent by the COVID-19 crisis. The opportunity exists to reimagine and redesign the health care delivery and education systems through a lens of health equity and racial justice. By so doing, during a pandemic that highlights the extent to which no one is safe until everyone is safe, health outcomes can be improved more broadly.

Increasing numbers of US medical students and physicians are already acclimated to understanding the importance of confronting inequities because many have been trained to understand the social determinants of health and its clinical adaptation, structural competency. Structural competency calls on methods from sociology, economics, urban planning, and other disciplines to systematically train health care professionals and others to "recognize ways that institutions, neighborhood conditions, market forces, public policies, and health care delivery systems shape symptoms and diseases."[7] Structural competency is also relevant for identifying the often invisible networks that support health, ranging from supply chains, to food delivery networks, to transit systems.

NYT Op-ed

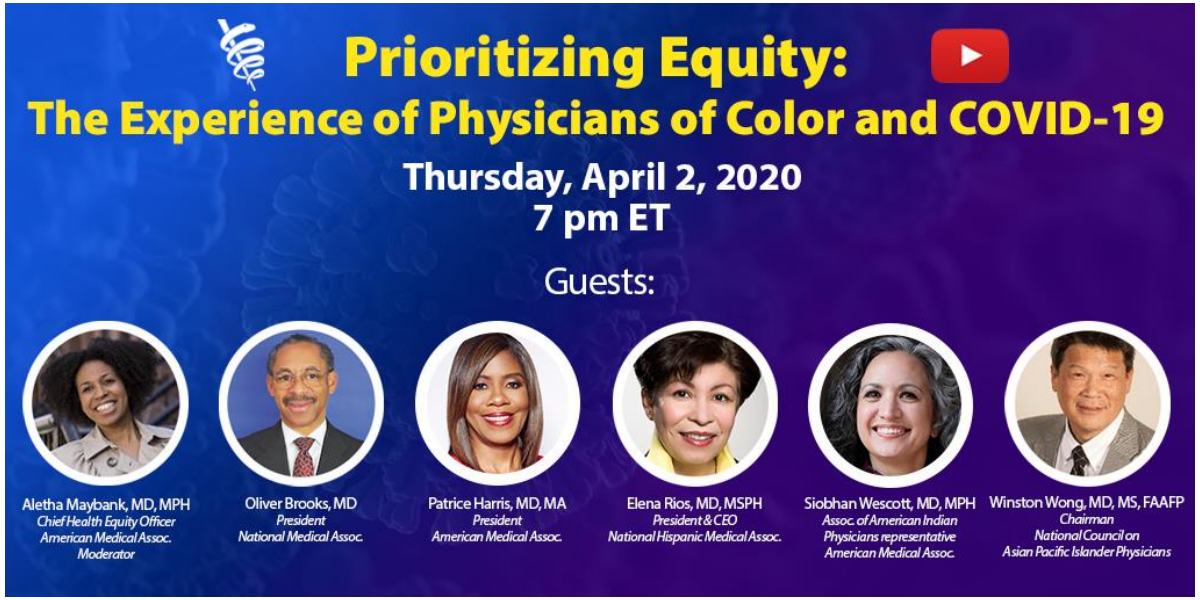
COVID-19 Health Equity Resource Center

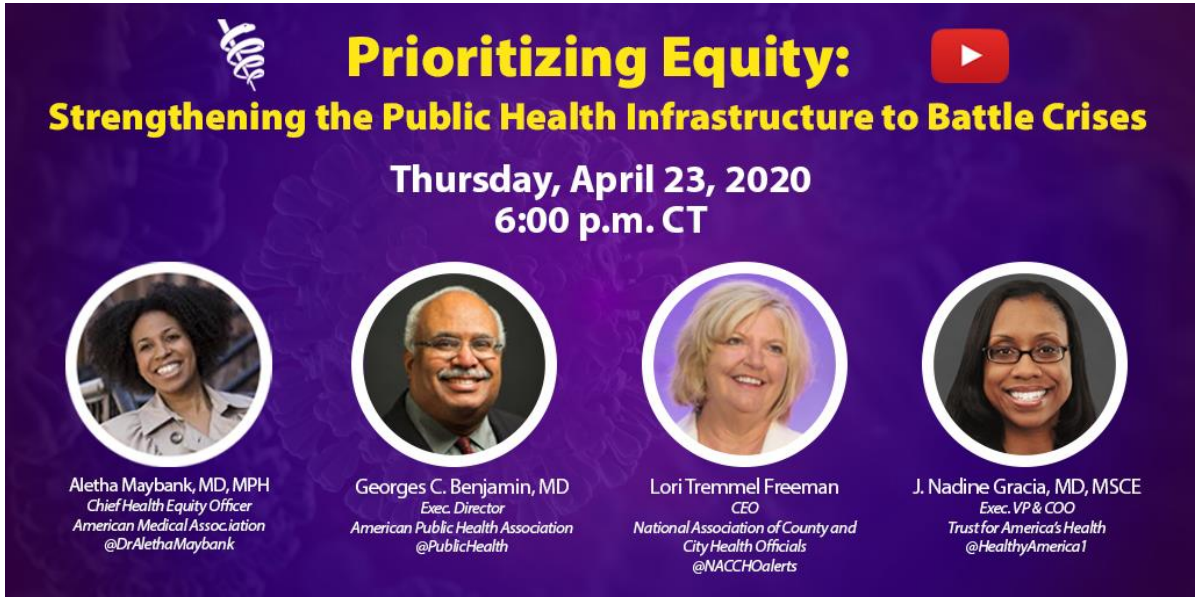


Oprah COVID –19 Series

Dr. Aletha Maybank @DrAlethaMaybank · Apr 14
Thank for gift & opportunity @Oprah to elevate racism in health. Thank you for shining light to make injustice visible. #COVID19

Oprah Winfrey @Oprah · Apr 14
.@DrAlethaMaybank founded the first center for health equity for the @AmerMedicalAssn. She seeks to provide underserved populations across the country with resources & access to quality healthcare. Thank you for your work #OprahTalks #COVID19
Show this thread





West Side United (WSU) is a collaborative effort of people and organizations who work, live and congregate on Chicago's West Side to make their neighborhoods stronger, healthier and more vibrant places to live. It is comprised of health care institutions, residents, civic leaders, community-based organizations, businesses, and faith-based institutions. To reduce the life expectancy gap between the Loop and Westside neighborhoods by 50% by 2030.

CDFI	Primary Focus
Accion	Small business development
LISC	Based on local "Quality of life plans" – affordable housing, community facilities, retail
Chicago Community Loan Fund (CCLF)	Affordable housing, community facilities, retail, capital and equipment, nonprofits
IFF	Large investments in below-market rate mortgages for nonprofit facilities or affordable housing projects.

Racial Equity Rapid Response

GOALS:

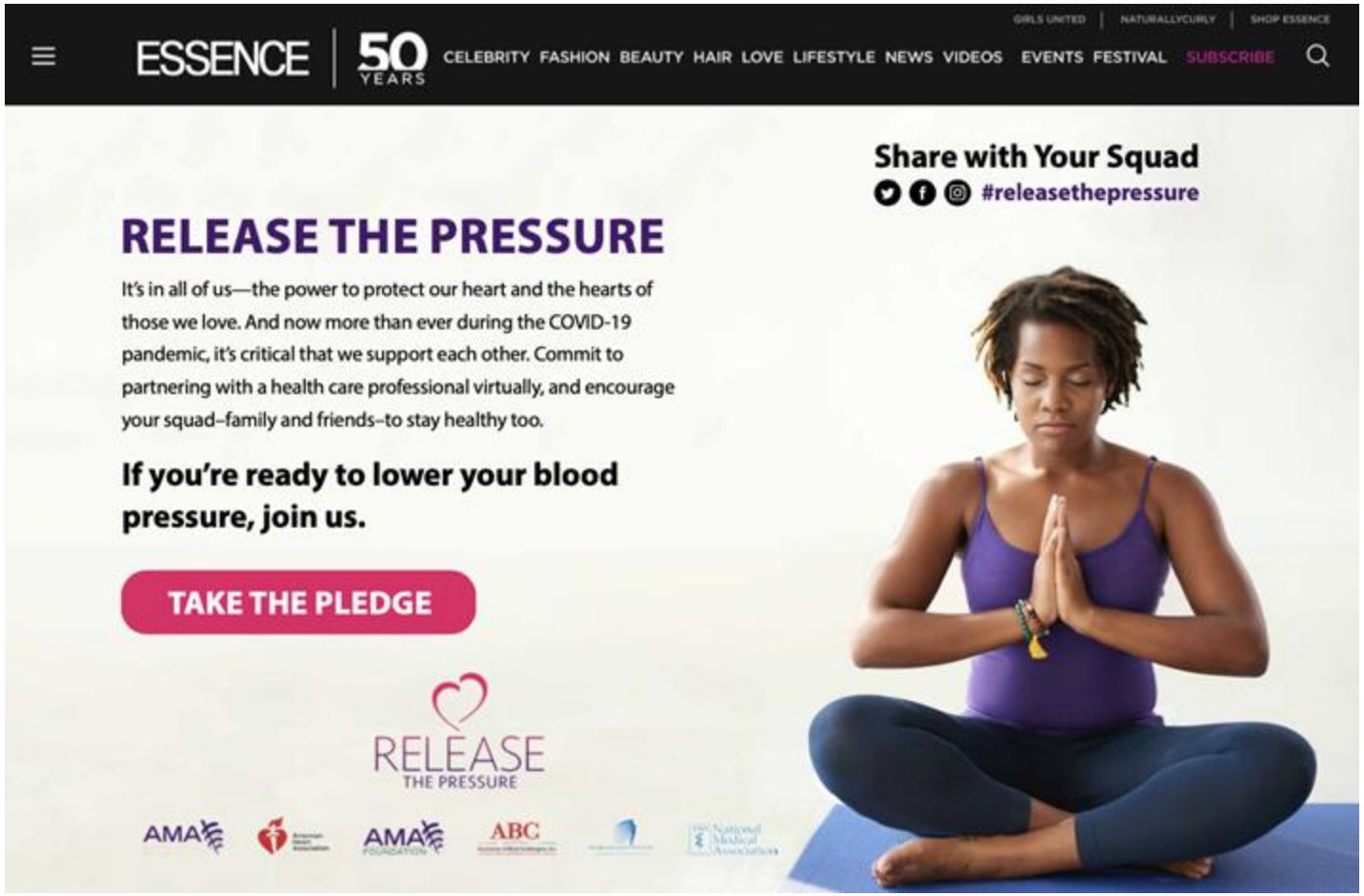
- **Flatten the COVID-19 mortality curve** in Black and Brown communities in Chicago
- **Build a groundwork for future work to address longstanding and systemic inequities** in Black and Brown communities (health, economic, and social)

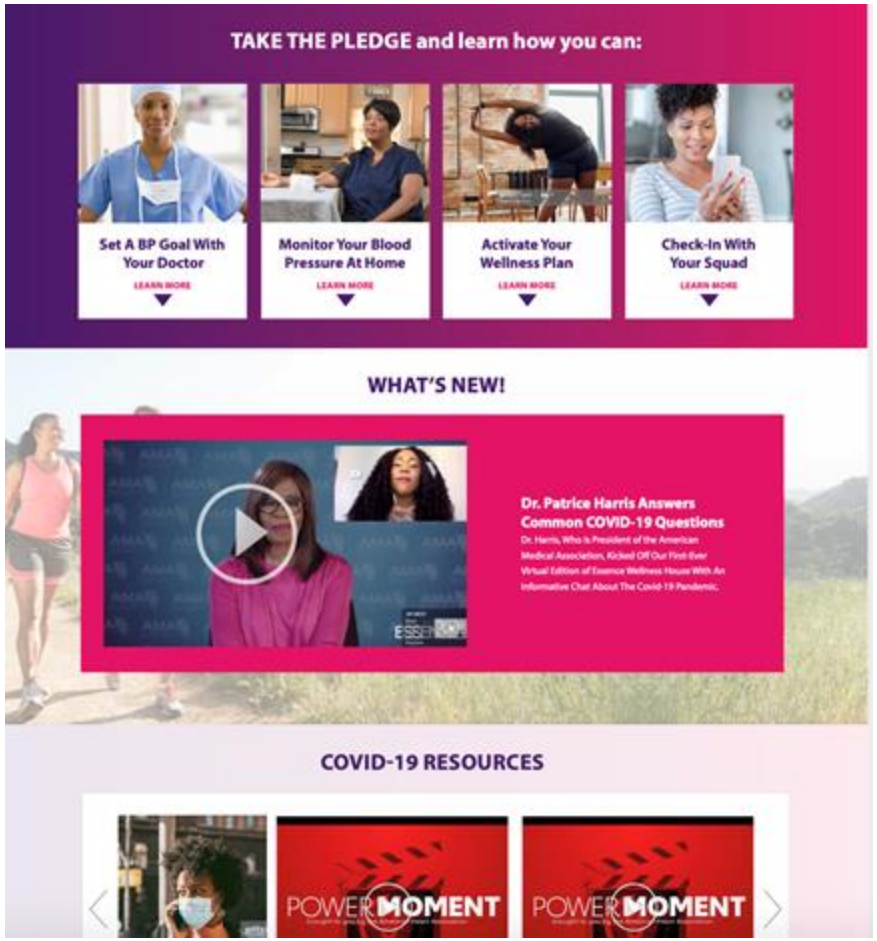
TACTICS:

- **Develop a city-wide community mitigation operation** that works hyper-locally in partnership with Black and Brown community organizers and leadership to mitigate CoVID-19 illness and death
- **Listen and respond to community-identified needs** within the context of partnership that is mutual and centered around benefitting, not burdening, Black and Brown communities
- **Marshal data, screening tools, testing, and human resources** needed to respond to community-identified barriers and needs

West Side United

Release The Pressure
High Blood Pressure + COVID-19





MENU AMA Join Renew Enter Search Term

Police brutality must stop

MAY 29, 2020

Jesse M. Ehrenfeld, MD, MPH
Board Chair
American Medical Association
Full Bio

Patrice A. Harris, MD, MA
President
American Medical Association
@PatriceHarrisMD
Full Bio

AMA policy recognizes that physical or verbal violence between law enforcement officers and the public, particularly among Black and Brown communities where these incidents are more prevalent and pervasive, is a critical determinant of health and supports research into the public health consequences of these violent interactions.

Recognizing that many who serve in law enforcement are committed to

Truth, Reconciliation, Transformation, & Healing

“….on behalf of the American Medical Association, I unequivocally apologize for our past behavior. We pledge to do everything in our power to right the wrongs that were done by our organization to African-American physicians and their families and their patients.

So yes, this history is still being written.

It noted that, "The [AMA's] expression of regret is the culmination of rigorous introspection. … There are those who say that apologies can't change the past, and they have a point. The hope is that they will change the future." We recognize that our apology is a modest first step toward healing and reconciliation. Just as Churchill said in 1942 after the "Battle of Egypt,"

This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning."

Ronald M. Davis, MD, AMA Immediate Past President @ National Medical Association (NMA) Annual Meeting, Atlanta, Georgia, July 30, 2008

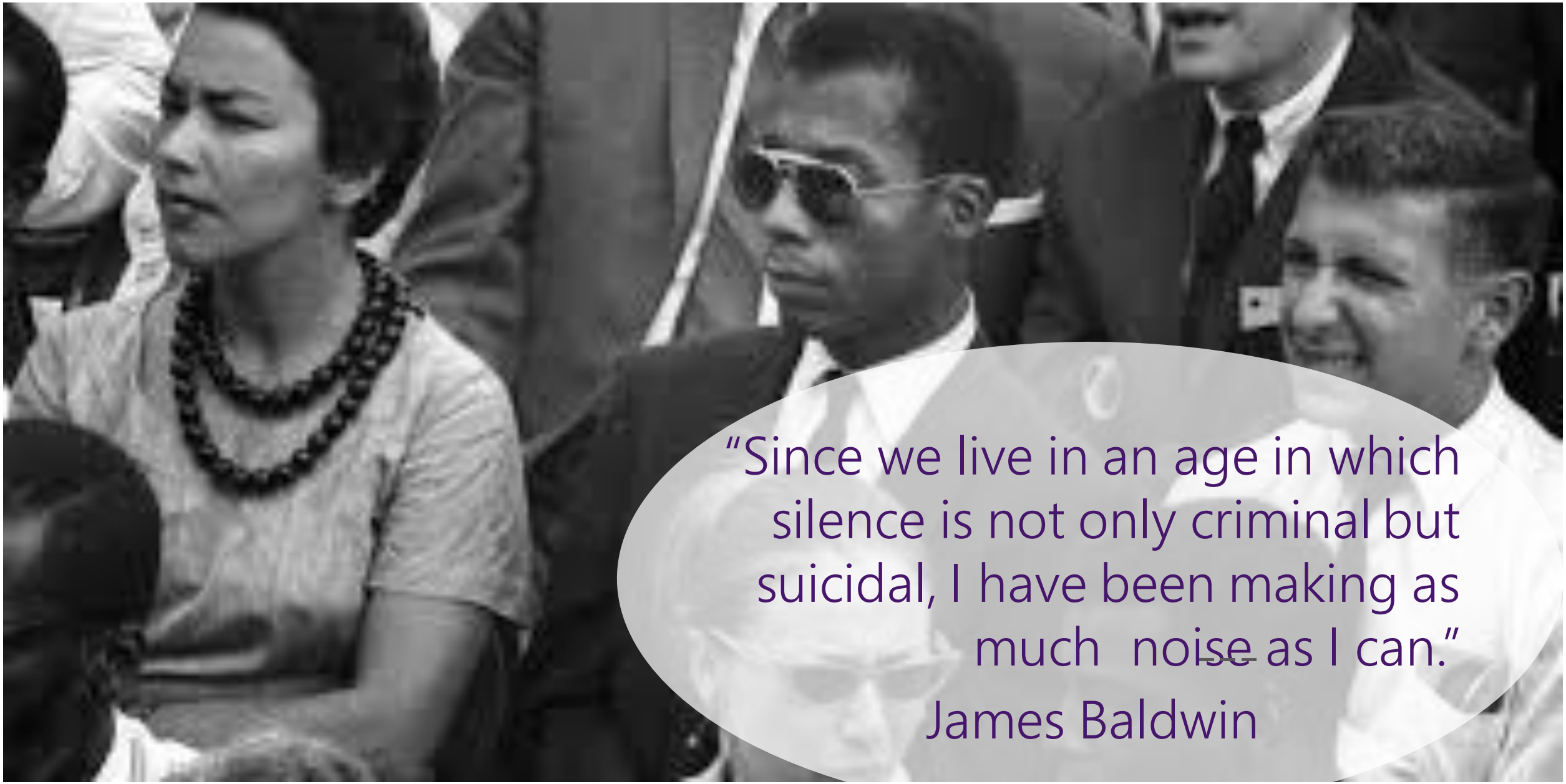
Equity needs from all of us…

Impact

Improved Health Outcomes

Closing Gaps (Disparities) in Health Outcomes

Do No Harm and No Further Harm



Aletha Maybank, MD, MPH
Member Since 2019

Thank You!