January 25th - Virtual MNORN Member Meeting

6:30- 7:00 PM - Social/Networking

7:00 - 8:00 PM - Program

Title of Program: PBM practices - What's Happening to Your Neighborhood Pharmacy?

Presenter: Hildie R. Hoeschen, RN, MSN, BA

Hildie has first hand experience of the impact of pharmacy benefit managers on neighborhood pharmacies. Her family owns St Paul Corner Drug, a fifth-generation family business. What is happening to this neighborhood pharmacy is happening to pharmacies throughout the state - both rural and urban.

WHAT IS A PBM?

Pharmacy Benefit Managers (PBMs) are "companies that manage prescription drug benefits on behalf of health insurers, Medicare Part D drug plans, large employers, and other payers" (The Commonwealth Fund, 2019).

In the American healthcare system, they're responsible for handling:

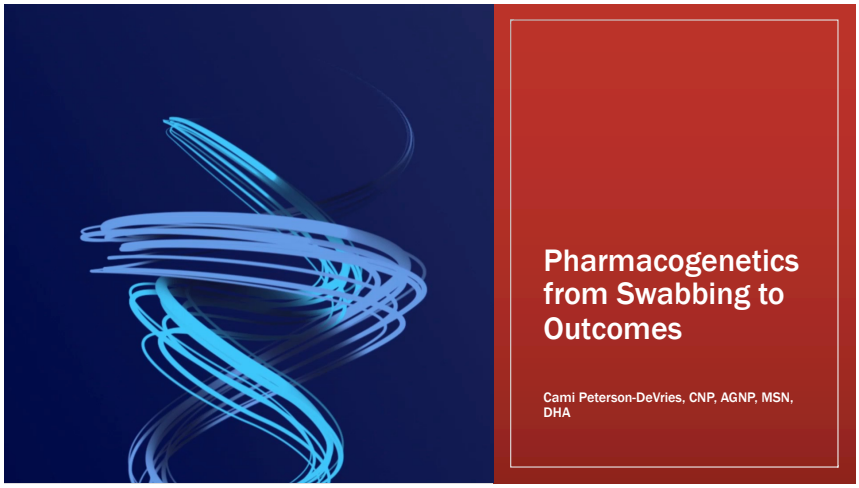
- The automated processing of Rx claims (i.e., they're the reason the billing of your prescriptions is increasingly convoluted, putting greater logistical burden on patients, providers, and payers)
- Creating the "formulary" of covered drugs for payers (i.e., they're the reason your medication is covered, your prescription requires a PA, or why you have to take the expensive brand-name version of a medication when a cheaper generic version exists)
- Negotiating rebates with drug manufacturers (i.e., they have a financial incentive to create formularies that include those manufacturer's drugs)
- Creating pharmacy networks
- Reviewing drug utilization
- Managing mail order specialty pharmacies

CLICK HERE TO REGISTER

Attendees will receive 1.0 continuing education credit

There is no charge for this meeting

Recording and Report of the December MNORN Member Meeting: Pharmacogenetics from Swabbing to Outcomes



CLICK HERE TO VIEW RECORDING

Pharmacogenetics is a field of research that studies how a person's genes effect how they respond to medications.

Presenter: Cami Peterson-DeVries CNP, AGNP, MSN, DHA

Cami currently is the VP of Corporate Compliance & Ethics and Leadership Development at St. Francis Health Services of Morris. Her background includes working in various parts of healthcare as a nurse including acute care, clinic, urgent care, home care, hospice, assisted living, and skilled nursing facilities. Along with her current position, she is also an adjunct professor at Rasmussen University and works in a small women's health clinic in rural Minnesota. Cami has a master's degree in nursing, a doctorate in healthcare administration, and is certified as an Adult-Geriatric Nurse Practitioner. She is a LeadingAge Minnesota board member and Chair for the Education Committee. Cami has a passion for nursing and enjoys mentoring others so they too can go out and make a difference. Cami is the First Vice President of MNORN.

Learning Objectives

- Describe the interconnection of medications and health outcomes
- Define methods of using pharmacogenomics in interdisciplinary practice
- Provide information on opportunities for nurses and health professionals to collaborate in precision medicine to impact population health.

Highlights of the presentation were:

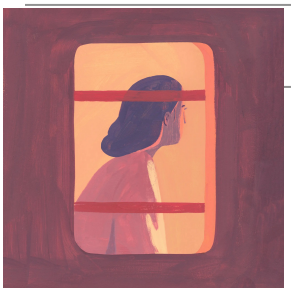
a. Focus in healthcare is changing to precision health.
b. Pharmacogenetics may identify patients who will have a very high or very low likelihood of responding to a medication.
c. Pharmacogenomics employs tools for surveying the entire genome to assess genetic responses to medications.
d. A brief genetic review was provided.
e. Studies indicate that integrating pharmacogenetics into personalized care can improve healthcare overall and may become part of routine practice.
f. This testing is relatively inexpensive ~$300 and is needed only once in a lifetime.
g. How can this improve healthcare? Pharmacogenetics can predict a patient's response to drugs, develop customized prescriptions, improve efficacy and compliance, minimize drug toxicities, and improve the accuracy of med dosing.
h. Despite its benefits, there are barriers to implementation of pharmacogenetics including cost, provider resistance/lack of knowledge, and misunderstandings of purpose.
i. One size does not fit all for medications. Tailoring medications to an individual's genetic make-up provides the most accurate, current way towards maximizing their effectiveness.

Cami presented a case study which greatly helped to exemplify how this testing can assist a patient and a provider.

Comments about the meeting included:

- Interesting topic,
- Our MNORN presentations this past year have been excellent to hear.
- It was new material for me
- I have a goal to attend as many of the MNORN meetings as I am able. I know I will always learn something. Thank you so much for a wonderful and informative presentation! I especially liked the emphasis on how the discussed approach to using genetic testing to inform decision-making around medication selection can be part of interdisciplinary and transdisciplinary work - with implications on an individual patient level and in population health.
- As a newer member, I want to become more involved and the scheduled time of this meeting was great
- To know more about the new happening in the profession
- Learning opportunity in topic of interest
- Knowledge acquisition and networking opportunities
- Thank you for this excellent presentation. I hope we see more of this topic's activity done in Minnesota in the next year.
- As always, thank you for another wonderful meeting! See you next time!

- I appreciated the opportunity and look forward to the next!
- Keep up these monthly education opportunities.
- Love the unique topics and easy access to CEUs
- Topic is new to me, we need to do more more of this (PGx)
- Well done! A very complicated subject!



Reporting on Long Covid Taught Me to Be a Better Journalist

By Ed Yong.

Mr. Yong is a science writer who covered the Covid-19 pandemic.

Dec. 11, 2023

In the early months of the Covid-19 pandemic, when many people who are now still sick were first infected, the common wisdom was that the coronavirus either sent you to an intensive care unit or, more commonly, caused mild symptoms that resolved after two weeks. But when my sister-in-law got infected in March 2020, she was still burning with fever after three weeks, then six, then more. In this newspaper and elsewhere, young and formerly healthy people shared stories about surviving but not recovering. When I interviewed scientists and clinicians about these lingering symptoms in May, most expressed surprise. "That's unusual," one said.

It wasn't. By May 2020, affected patients had already formed support groups thousands strong, coined terms like long Covid and long-hauler and even conducted research on their own communities. Even that March, people with similar illnesses like myalgic encephalomyelitis (also known as chronic fatigue syndrome or M.E./C.F.S.) had warned that the new pathogen would trigger a wave of disability. They knew then what is clear now: People infected by Covid can be pummeled by months or years of debilitating symptoms, including extreme fatigue, cognitive impairment, chest pain, shortness of breath and postexertional malaise — a state in which existing symptoms worsen after even minor physical or mental exertion.

I wrote about long Covid in June 2020. In the following days, I got more than 100 emails from people who thought they were going mad — or had been told as much — and felt validated to see their reality reflected. That story was the first of an octet; those responses were the vanguards of thousands more.

Long-haulers have told me that through those pieces, they better understood what was happening to them, found community and medical care, and felt the relief of recognition at a time when friends, family members and health care professionals brushed off their

ordeal as imaginary. As a science writer, I have written about many topics throughout my career. None have affected me more than long Covid. None have more profoundly changed my view about what journalism can achieve and how it can do so.

Covering long Covid solidified my view that science is not the objective, neutral force it is often misconstrued as. It is instead a human endeavor, relentlessly buffeted by our culture, values and politics. As energy-depleting illnesses that disproportionately affect women, long Covid and M.E./C.F.S. are easily belittled by a sexist society that trivializes women's pain, and a capitalist one that values people according to their productivity. Societal dismissal leads to scientific neglect, and a lack of research becomes fodder for further skepticism. I understood these dynamics only after interviewing social scientists, disability scholars and patients themselves, whose voices are often absent or minimized in the media. Like the pandemic writ large, long Covid is not just a health problem. It is a social one, and must also be understood as such.

Dismissal and gaslighting — you're just depressed, it's in your head — are among the worst aspects of long Covid, and can be as crushing as the physical suffering. They're hard to fight because the symptoms can be so beyond the realm of everyday experience as to seem unbelievable, and because those same symptoms can sap energy and occlude mental acuity. Journalism, then, can be a conduit for empathy, putting words to the indescribable and clarifying the unfathomable for people too sick to do it themselves.

Many long-haulers have told me that they've used my work to finally get through to skeptical loved ones, employers and doctors — a use that, naïvely, I didn't previously consider. I had always imagined that the testing ground for my writing was the minds of my readers, who would learn something new or perhaps even change what and how they think. But this one-step model is woefully incomplete because we are a social species. Journalism doesn't stop with first-generation readers but cascades through their networks. Done well, it can make those networks stronger.

After my most recent piece, which explained how severe the fatigue of long Covid and M.E./C.F.S. can be, one long-hauler told me that her sister said, "I did not understand how sick you really felt." Even healthy people started writing in: A 25-year-old reader who has spent her life watching her mother wrestling with M.E./C.F.S. said that until reading that piece, "I truly didn't get it (or maybe didn't believe her)." People who had been sick for years or even decades said it was the first time they had seen their lives accurately, fully and compassionately reflected in the press.

This is a damning indictment of my profession, my prepandemic self included. I am far from the only journalist covering this topic but clearly there aren't enough of us. How could so

many people feel so thoroughly unrepresented by an industry that purports to give voice to the voiceless?

In covering conditions like long Covid and M.E./C.F.S., many journalistic norms and biases work against us. Our love of iconoclasts privileges the voices of skeptics, who can profess to be canceled by patient groups, over the voices of patients who are actually suffering. Our fondness for novelty leaves us prone to ignoring chronic conditions that are, by definition, not new. Normalized aspects of our work like tight deadlines and phone interviews can be harmful to the people we most need to hear from.

We cannot afford those weaknesses. Around the world, tens of millions of people are suffering from long Covid. Some might recover but most long-haulers don't fully return to their previous base line. At the same time, the pool of newly sick people will continue to grow since our leaders have rushed us back to an era of unrestrained airborne pathogens and lax public health policies — an era that had already cost millions of M.E./C.F.S. sufferers dearly long before Covid arrived.

In this status quo, people are expected to ignore the threat of infection, pay through the nose if they get sick and face stigma and ridicule if they become disabled. Journalism can and should repudiate that bargain. We are not neutral actors, reporting on the world at a remove; we also create that world through our choices, and we must do so with purpose, care and compassion.

Interviewing long-haulers isn't benign. At minimum, I might be asking them to relive their worst experiences to a stranger. Worse, many, if not most, long-haulers experience postexertional malaise, in which minor physical or mental exertion can trigger a loss of energy so profound that I've described it as the annihilation of possibility. An hourlong call could wreck someone for days.

Knowing this, I started telling people upfront that they could end and reschedule the interview at the slightest inkling that their health might suffer — and some did pull that rip cord. I set long deadlines, knowing that I was working on what disability scholars have called crip time. While I usually insist that phone interviews yield better results, I happily sent written questions to long-haulers who struggled with real-time spoken conversations. Good journalists maintain a healthy distance from their sources, but this professional standard can morph into callousness: Staying independent can easily become, "I behave how I want and you deal with it." With long Covid, I bend to accommodate my sources' needs, not the other way around.

I bring as much curiosity and empathy as I can to interviews. I'm not fishing for quotes or dramatic details of horrible symptoms. I want to know how long-haulers feel, including the

nuances and minutiae of their lives. I check my own thoughts on the fly, running my interpretations past my sources in real time to check if my understanding and assumptions are correct. I do this iteratively, asking them if they have had the same or similar experiences of the previous sources I've interviewed, to identify points of commonality or contention; everyone is wrong about something, and being empathetic doesn't mean abandoning rigor.

This approach reveals sides to the illness that are easily missed. For many long-haulers, fatigue differs from everyday tiredness — more severe, multifaceted, harder to push through and not cured by sleep. Postexertional malaise is different again: Every symptom burns more fiercely; fatigue is accompanied by flulike, poisoned sensations; and one's batteries aren't just drained but missing entirely. These states are all too easily conflated, and their differences became clear to me only after many interviews and much careful listening.

I also center long-haulers in my reporting, treating them as active protagonists of their own stories instead of passive beneficiaries of medical aid. I want readers to empathize, not gawk. The patient-centric approach is sometimes dismissed as advocacy, which is positioned as antithetical to journalism. In fact, it's simply good journalistic practice to give weight to the most knowledgeable sources.

Long-haulers saw and predicted the rise of long Covid before credentialed academics did. Many are patient experts who have read the scientific literature on long Covid and M.E./C.F.S. more deeply than many doctors because they are highly motivated to do so. Others are meta-experts who thoroughly understand the community's desires, needs, history and rifts, and can distinguish reliable voices from grifters. They should be front and center of every story, not merely fodder for anecdotal ledes. Before the pandemic, I mostly interviewed academics with advanced degrees and institutional affiliations. Long Covid taught me to also seek expertise from actual experience, instead of mere credentials. (This is now especially easy to do because large databases of sources have been compiled.)

Those new attitudes and approaches also informed other articles that I wrote about immunocompromised people, burned-out health care and public health workers and people grieving loved ones who died of Covid. Those pieces, about people who had borne the brunt of the pandemic and were still suffering amid the rush to "normal," gave me a sense of purpose amid deepening tragedy.

As the pandemic wore on, many grim outcomes I warned about came to pass, and most societal changes I hoped for did not. I watched two successive administrations make avoidable mistakes, and then make them anew with each successive surge or variant. I witnessed almost every publication that I once held in esteem become complicit in normalizing a level of death once billed as incalculable. It was galling, crushing work that

wrecked my faith in journalism and its institutions. But the solace that many long-haulers drew from my pieces gave me solace in turn. It convinced me that there is still a point to this horrible work, a purpose in bearing witness to suffering and a reason to continue shouting into the abyss. Sometimes, even if just slightly, the abyss brightens.

I do not mean to be self-congratulatory. The long Covid crisis is far from resolved. Long-haulers need more than confirmation of their pain: They need well-funded and well-conducted research, social support, workplace accommodations and cures. But there is much we can do while waiting for and pushing toward those outcomes.

In his poem "Why Bother?" Sean Thomas Dougherty wrote, "Because right now, there is someone/out there with/a wound in the exact shape/of your words." Those words are ours to provide, those wounds ours to plaster. Contrary to the widespread notion that speaking truth to power means being antagonistic and cold, journalists can, instead, act as a care-taking profession — one that soothes and nurtures. And we are among the only professions that can do so at a scale commensurate with the scope of the crises before us. We can make people who feel invisible feel seen. We can make everyone else look.

https://www.nytimes.com/2023/12/11/opinion/long-covid-reporting-lessons.html
retrieved 12/12/2023

Illustration by Holly Stapleton

ANA Advocacy Focuses on Safe Staffing, Looks to Opportunities in the New Year

Zina Gontscharow & Simit Pandya
December 14, 2023

Achieving safe staffing levels continues to be one of the biggest challenges facing nurses at the bedside. Workforce shortages, while not new, are being deeply felt across the country. The COVID-19 pandemic exacerbated existing shortages and has led to significant burnout among our nurses, driving even more nurses out of the profession. These shortages are unsustainable, making it even more vital that policymakers act now to identify and take action on new approaches to addressing safe staffing and other workforce challenges.

At ANA, we recognize this issue is essential to our nurses and are working hard to make real change at the federal level by advocating for the Administration and Congress to

recognize and address this crisis. Through our regulatory advocacy, ANA has reached out to Centers for Medicare & Medicaid Services' (CMS') Center for Clinical Standards & Quality as well as the White House Domestic Policy Council to call for more meaningful conditions of participation that provide additional requirements and enforcement mechanisms for staffing at acute care hospitals.

More recently, ANA submitted comments on CMS' proposal to institute the first-ever ratios for staffing in long-term care (LTC) facilities. As directed by an Executive Order issued by President Biden, CMS was tasked with studying staffing levels in these facilities and issuing regulations aimed at improving nurse staffing levels to enhance patient care quality. CMS issued a proposed rule in early September that would set minimum ratios for registered nurses (RNs) and nurse aides and require an RN onsite 24/7, among other implementation and enforcement requirements. When finalized, this proposed regulation will set a precedent for federal staffing requirements that could bolster our advocacy efforts related to safe nurse staffing in other settings as well.

This proposed regulation is so significant that, in addition to our comment letter, we also submitted a coalition letter to the agency that included 25 state nursing and organizational affiliate associations. Both letters echo previous calls for the Administration—CMS and other federal agencies—to work closely with the nursing community and other stakeholders to take real action to address workforce needs and challenges.

As part of our legislative advocacy, ANA recently endorsed the *Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act* (H.R. 2530/S.1113), introduced by Senator Sherrod Brown (D-OH) in the U.S. Senate and Representative Jan Schakowsky (D-IL-9) in the U.S. House of Representatives. This bill would establish **minimum nurse-to-patient staffing ratios** in hospitals to help ensure patients have access to nurses who can provide them with the time and attention necessary to deliver high quality patient care**.** ANA sees the adoption of safe staffing levels as part of a multi-pronged approach to addressing the work environment challenges resulting in burnout and workforce attrition among nurses.

As we look to 2024, ANA will continue the drumbeat with federal policymakers about the critical need to take real action to address safe staffing for our nation's nurses. We will keep pushing federal agencies to use their existing authority to ensure safe staffing levels in the health care facilities under their purview, while watching closely for CMS to issue the final rule on LTC facilities. ANA will also seek opportunities to call on Congress to implement safe staffing standards, while identifying and pushing back against any policies that could further exacerbate the nurse staff workforce crisis. Together with our members, we will continue to make real strides in addressing safe staffing for nurses and the patients they serve.

Have You Applied for your Unique Identifier Yet?

Enroll in the NPI at https://nppes.cms.hhs.gov/#/, It is free and easy to do.

ANA - Nurse provider identifier

"Registered nurses (RNs) are integral parts of the health care team and spend significant time with patients providing clinical services. In the current health care financing system, this work is generally not accounted for, other than in the physician's practice expense (PE) relative value unit (RVU). The lack of NPIs for nurses makes it extremely difficult to record, measure, and value the services they provide and their impact on patient outcomes…..Obtaining and recording NPIs in appropriate healthcare data systems would allow health systems, payers, and enterprise resource planning systems to extract nursing services from other providers. This then allows for a quantitative analysis and substantive demonstration of the nurse's role and value as an integral member of a patient's health care team."

NPSNetwork Nurses Peer Support Network

Nurses Peer Support Network (NPSN)

"**Alcohol** and other substance use by nurses places patients, the public, and nurses **at risk for serious injury or death**."

Minnesota is home to more than **150,000 licensed nurses**. Substance Use Disorder (SUD) is a chronic disease which afflicts one in ten people in the general population and perhaps more among nurses because of the number of high risk factors associated with the profession.

SUD is a treatable disease.

Established in 2014, the **Nurses Peer Support Network** (NPSNetwork) offers hope and healing through peer support in a safe environment for nurses in recovery. NPSNetwork also provides education and outreach about Substance Use Disorder in nursing to promote safety to the public.

It is the **vision** of NPSNetwork that **all nurses in Minnesota will have access** to community-based peer support for substance use disorder.

MNORN is a proud supporter of NPSN.

CLICK HERE TO READ THE MOST CURRENT NEWSLETTER

CLICK HERE TO LEARN MORE ABOUT NPSN

Back to the future: Social determinants of health and health equity require our attention now.

By: Joseph Potts, MSN, RN, CNML
December 12, 2023

Horror Vacui—nature abhors a vacuum. This principle applies to leadership as much as it does to physics, although perhaps a little more difficult to predict. I recently spoke with some colleagues about the impact of the Federal Public Health Emergency declaration ending and how to face the challenge of figuring out where to direct the time, attention, and energy we've focused on navigating our teams through the pandemic. It occurred to me that we already have a great roadmap for this—the Future of Nursing Report.

You might first remember the iconic The Future of Nursing: Leading Change, Advancing Health, published over 10 years ago by what was then known as the Institute of Medicine. The agency has a new name—The National Academy of Medicine—and they've worked with a diverse team of experts from across the nursing spectrum to create a new visionary report titled The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity. It outlines key recommendations for propelling nursing into a new era where we address social determinants of health and work toward health equity. (See *Health equity recommendations*.)

As you can see from some of the dates, we've already fallen behind. Thankfully, there's no better time than the present to start addressing the future. Read the report (bit.ly/45OukCP) and begin working with your colleagues and organizations to advance this important work.

Health equity recommendations

1. **Forge a shared agenda:**In 2021, national nursing organizations should collaborate to develop a shared agenda for addressing social determinants of health and achieving

health equity, focusing on nursing practice, education, leadership, and health policy engagement.

2. Create a comprehensive approach: By 2023, various entities, including government agencies, healthcare organizations, payers, and foundations, should take significant actions to empower the nursing workforce to address social determinants of health and health equity across different practice settings.

3. Promote nurses' well-being: By 2021, nursing education programs, employers, leaders, licensing boards, and organizations should implement structures, systems, and evidence-based interventions to promote nurses' health and well-being, particularly as they take on new roles to advance health equity.

4. Remove barriers to full practice: All organizations, including government entities and employing organizations, should eliminate barriers that prevent nurses from fully addressing social needs and determinants of health by practicing to the full extent of their education and training.

5. Provide sustainable financial support: Payers and public health agencies should establish sustainable and flexible payment mechanisms to support nurses, including school nurses, in addressing social needs, social determinants of health, and health equity.

6. Embrace technological innovation: Healthcare systems should incorporate nursing expertise in using diverse digital platforms, artificial intelligence, and other innovative technologies to design, generate, analyze, and apply data for initiatives related to social determinants of health and health equity.

7. Redesign education for the future: Nursing education programs and accreditors should ensure that nurses are prepared to address social determinants of health and achieve health equity, including through continuing education.

8. Strengthen the workforce: During public health emergencies and natural disasters, federal agencies and stakeholders should support and protect the nursing workforce, enabling them to address inequities within communities.

9. Conduct collaborative research and partnerships: Key stakeholders should collaborate to develop a research agenda and evidence base on the impact of nursing interventions, including multisector collaboration, on social determinants of health, environmental health, health equity, and nurses' health and well-being.

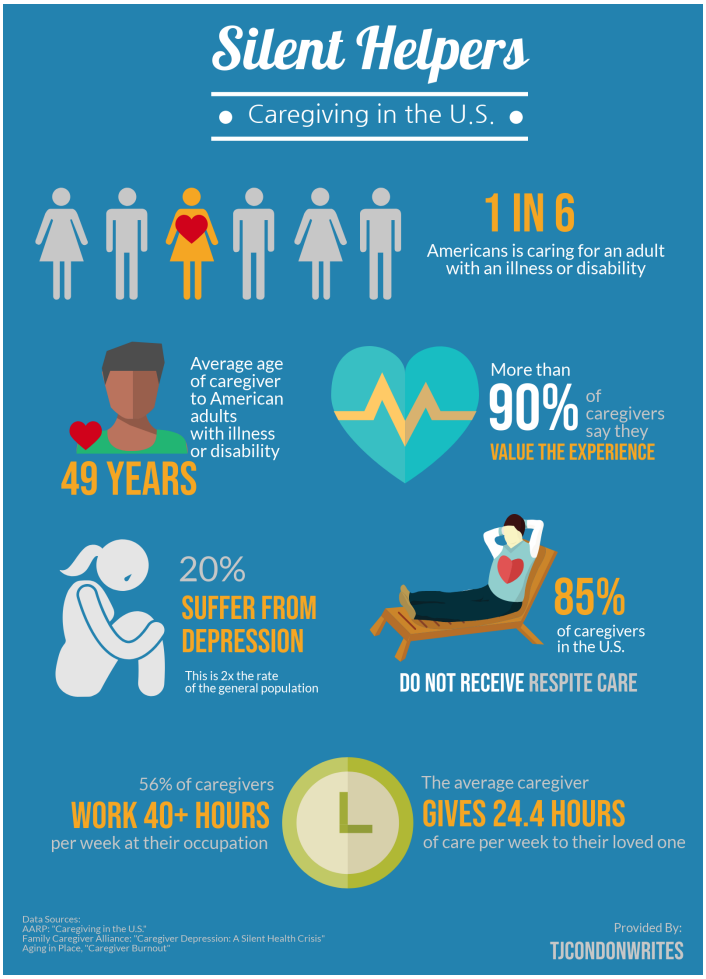
Joseph Potts is on the American Nurse Journal Editorial Board and is the manager of clinical services at Peace Island Medical Center in Friday Harbor, Washington.

American Nurse Journal. 2023; 18(12). Doi: 10.51256/ANJ122346

retrieved 12/19/2023 https://www.myamericannurse.com/back-to-the-future/?partnerref=Nurseline+20231219&utm_source=sfmc&utm_medium=email&utm_campaign=Nurseline+20231219&utm_term=Back+to+the+future&utm_id=123960&sfmc_id=11528074

Here's to all the silent helpers, caring for their loved ones day in and day out.

If you are a family caregiver, know that your work is important and you are appreciated. If you know a family caregiver, check on them and offer to do something to lighten their load: bring a meal, do a load of laundry, pick up their groceries, sit with their loved one so they can engage in self-care, or better yet—ask them what would be most helpful.



retrieved from End in Mind https://www.endinmindproject.org/ 11/02/2023

New MDH Project Firstline Resource

Respiratory Illness Resource Infection control measures to prevent and slow the spread of viral respiratory infections like influenza, RSV and COVID-19

Infection Control for Respiratory Viruses

Use the following infection control measures to prevent and slow the spread of respiratory infections in your facility.

Use of well-fitting masks or respirators, that cover a person's mouth and nose, can prevent the spread of germs when people are breathing, talking, sneezing, or coughing.

Encourage everyone in your facility to get recommended vaccinations. Vaccination is a safe and effective strategy for reducing disease spread and staff absenteeism.

Practice physical distancing, particularly in shared spaces such as waiting rooms, and implement screening and triage procedures. Use signs as visual reminders for patients, implement rapid screening, and separate symptomatic patients as soon as possible.

Practice respiratory hygiene and cough etiquette and encourage others to do the same. Provide masks, tissues, and no-touch receptacles for tissue disposal at facility entrances, triage areas, and waiting rooms.

Clean your hands regularly with an alcohol-based hand sanitizer or soap and water. Share key messages and reminders within in your facility by using CDC's Clean Hands Count resources.

Clean and disinfect regularly. Lobby areas, cafeterias, and waiting rooms are all high-traffic spaces where germs can spread. It's also important to disinfect reusable devices and not reuse disposable items.

Check that the air handling in your facility is functioning as it should. Make sure air vents aren't blocked, and consult with facilities management to ensure the heating, ventilation, and air conditioning, or HVAC, system is working efficiently for proper ventilation.

For more information on infection control recommendations for healthcare settings, visit https://bit.ly/3O1UXhM

www.cdc.gov/ProjectFirstline

WE HAVE THE POWER TO STOP INFECTIONS. TOGETHER.

CDC PROJECT FIRSTLINE

Infection Control for Respiratory Viruses (cdc.gov)

Coming Soon: Recorded Project Firstline Table Talk Sessions
These (live) training session recordings will be posted to our website soon!

- Infection Prevention & Control Actions to Stop the Spread of Viral Respiratory Infections
- Thankful Thursdays COVID-19 Refreshers
- Hand Hygiene

Visit: MDH Project Firstline Training and Resources webpage, and remember to complete the feedback survey after viewing recorded training to receive your *Proof of Attendance*.

Stay up-to-date with Project Firstline by subscribing to our mailing list: Subscribe to the Project Firstline mailing list

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Happy New Year from MNORN!