

The Lewin Group
Emergency Preparedness Planning for Persons with Disability
August 24, 2022

Laura Maynard: Welcome, everyone. We're glad that you're with us today. Thank you for joining us on this webinar for emergency preparedness planning for persons with disabilities. My name is Laura Maynard, and I'm with the Lewin Group. Today's session will include presentations followed by a panel discussion and some live Q&A sessions with the panelists and participants. Video replay of today's session will be available at the resourcesforintegratedcare.com website.

This webinar is supported through the Medicare Medicaid Coordination Office and the Centers for Medicare & Medicaid Services to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools that are based on successful innovations with successful care models. And this webinar is one example of that. To learn more about current efforts and resources in this area, visit [Resources for Integrated Care](https://resourcesforintegratedcare.com). The link is there on the screen, resourcesforintegratedcare.com. That link is also in the resource panel on your webinar platform. Or join us on Twitter at [@Integrate_Care](https://twitter.com/Integrate_Care).

This time we want to find out a little bit about who's with us today for the webinar. So we're going to launch a couple of polls, and the first we would like to ask: Which of the following best describes your professional area? So, in which of these areas do you work? Click the one that comes closest to your type of work that you do. Are you a health plan case manager care coordinator? Are you in customer service with a health plan? Are you in health plan administration or management? Do you identify yourself as being in medicine, nursing, a physician assistant, or some other provider? Are you involved with pharmacy? Do you work in the social work area? Or are you more in advocacy? And we're going to give just a few seconds for everyone to mark so that we have a sense of the professional areas represented. And that will help us see who's on the webinar today, who makes up the audience. We'll give you just a few more moments to respond to that. About 60% of you have responded so far, so that's great. I'm going to give you just a few more—yeah, I see someone asking, what about those of us in more than one? It will only let you pick one, so just pick one of your more than one. Any one will do. So just the one that fits the best. Some of them may not fit exactly. All right, I think we've reached a critical mass of responses to this one, so we can move now and show the poll results.

By far, almost half of you are health plan case managers or care coordinators. The next largest are health plan administration and management. About 17% there. Providers of various sorts. Social workers of various sorts, and a few that are in customer service. And as noted through the chat, through the Q&A chat, a few that don't really quite fit into any of those categories.

And one more quick poll. In what care setting do you work? Do you work for a health plan or are you more in an ambulatory care setting, long-term care facility, a home care agency, a community-based organization, consumer organization, or more an academic and research

area? So take a moment just to click which one of those best applies. If none of them apply, you can also put your response into the Q&A panel or pick the one that fits the best, that's sort of the closest fit to where you work. I'm going to give you just a moment or two to complete the polling. Okay. We're getting there. We've got about 64% of you that have responded. We're going to give another moment or two. And I appreciate those of you that are from particular health plans or in government agencies that are typing into the Q&A to indicate that.

All right. We're going to show the results. About 65% are with health plans. We have a few with long-term care and home care. And 14%, community-based organizations, which is great to have that representation, and consumer organizations as well. So, wonderful. Very few academic and research, and then several others. Okay. Thank you for letting us know about you.

Let me now let you know a little bit about our speakers. I'm going to introduce all of our speakers on today's webinar. June Isaacson Kailes is a Disability Policy Consultant, and she is a pioneer, leader, and innovator in healthcare, in emergency management, in aging with disability, in stakeholder engagement, and in hospitality. The breadth and depth of her experience in disability, accessibility, and functional needs issues is widely known, and she is respected as a writer, trainer, researcher, policy analyst, subject matter expert, and advocate. We also have with us today Sarah Fitzwater, the Director of Clinical Operations with iCircle, Samantha Bartz, the Director of Clinical Services at iCircle, Stephanie Rasmussen, the Vice President of Long-Term Services and Supports with Sunflower Health Plan, Christina Mills, the Senior Director of Inclusive Policy and Advocacy with Elevance Health, and Merrill Friedman, the RVP of Inclusive Policy and Advocacy at Elevance Health. So we're looking forward to hearing from all of them.

Our objectives for today, we expect that as a result of attending this webinar, you'll be able to understand populations and identify persons with access and functional needs. And these include, but are not limited to, people with disabilities, people with limited English proficiency, limited access to transportation and financial resources, older adults, and others deemed at risk. You'll also be able to identify the role of care management and care coordination in including emergency preparedness planning in member care plans, including identifying members at high risk before, during, and after emergencies. And to identify steps that health plans can take to prepare beneficiaries and their caregivers for emergencies and natural disasters. We also hope that you'll be able to understand the benefits of emergency preparedness for dually eligible individuals.

Here's the outline for what we're going to cover today after a brief introduction. We'll be hearing about strengthening emergency planning and response roles for health plans serving people with disabilities. We'll have a brief presentation on developing person-centered emergency preparedness plans, one on a managed long-term services and supports plan perspective, then another on emergency planning with people who have access and functional needs. We'll move then to a panel discussion, and then Q&A with the different panelists and presenters.

By way of introduction to this, people with disabilities and others who have access and functional needs really represent a very large and diverse group. This includes people who

experience limitations in behavior, limitations in walking, balancing, climbing, seeing, reading, hearing, speaking, limitations in understanding and remembering, as well as folks that may have chemical sensitivities. And many of these functional needs are under-recognized and undercounted in various population counts and data. There are many more people who experience disabilities and functional needs than the commonly-referred-to one in five individuals. This segment of people who have functional and access needs is estimated to be up to 50% of the population. Those who rely upon accessibility supports and devices and equipment and on personal care services in their daily lives, these folks are disproportionately affected by disasters. In emergencies, functional needs can increase significantly. People may not have access to the equipment and devices and supplies and aids that they need in their everyday environment, and this lack of access can contribute to their decreased independence in these situations. People may, for example, depend upon breathing machines or wheelchairs, lifts, elevators, medications, personal care assistants, and many other supports for survival and for evacuation in emergencies. Emergency preparedness planning should address the specific functional needs of the individual, as well as the variety of potential emergencies that they may face. These emergencies may include natural disasters like fires, floods, tornadoes, hurricanes, but also things like terrorist attacks or mass shootings, public health emergencies such as pandemics, power outages, chemical spills, and many others. Health plans play a key role in providing supports and services for people who have access and functional needs. So we're hoping that in today's presentations, you'll hear some ideas and some strategies for helping folks with access and functional needs be adequately prepared for emergencies or disasters.

To begin that, I'm happy to introduce June Isaacson Kailes. She's going to share with us on strengthening emergency planning and response roles for health plans serving people with disabilities. June?

June Isaacson Kailes: Hey, Laura, thank you. And glad to be here today. I'm talking to you from Los Angeles. So, next slide.

I'm going to cover today why health plans can be a critical resource before, during, and after disasters and emergencies, the important role of case managers and care coordinators in planning response and recovery with members, the importance of key partners, particularly community subject matter experts, and attention to meaningful measures in terms of looking at effectiveness and impact that we have with members. Next slide.

So my content integrates information from a 2021 report that takes an in-depth look at health plan emergency member focus practices. And you'd just find this report if you type in the title in any search engine, and this slide represents some of the pre-planning funders and the main funder of the investigation, which was the Craig Nielsen Foundation. So in that report, you'll find lots of actionable pathways for applying and accelerating and embedding and sustaining of customizable processes and policies and training and exercises and community partnerships. So today, we're going to take a brief look at health plans' emergency roles with members. The why, the detail of the roles, the partners, and the measures. So, next slide.

So, we've got another poll here. And the questions are, indicate which is not true of health plans. That they touch and serve more people with disabilities than any other service system. Next, in emergencies they're often under-recognized and underutilized, and last, they're an

essential emergency partner with many resources and capabilities. So, which of these items is not true? And you all can let us know how that turned out.

Laura Maynard: So I encourage folks to answer the poll. Click which one applies for you, which one you think may not be true of health plans. Only got about 18% of you that have responded so far, so I would encourage others to make a guess and pick which one you think.

We'll give you just a few more seconds on that. Getting a few more responses as we go. Aha, I see someone saying in the Q&A panel that this is a tricky question. Yes. We've got about 60% of responses, of people that have responded now. June, would you like for me to go ahead and show the results?

June Isaacson Kailes: Yes.

Laura Maynard: So it was a bit of a tricky question. About 49% said that health plans are often, are not often under-recognized and underutilized in emergencies. About 30%, the first one, that plans don't touch and serve people with disabilities more than any other service system, and only about 21% say that plans don't act as an essential partner with many needed resources and capabilities.

June Isaacson Kailes: Okay. Well, then you are on your game. This is really kind of a trick question. It should've said one more push, which is, all are true here. These are all actually true. So, you can throw something at me, it's okay.

Okay. Next slide. We're going to ask you to listen today using your lens as health plan care coordinators and managers, just really your roles. Think about what you might want to start or stop or change or continue. So next slide.

Why this focus? Because people with disabilities, Laura actually said, and others with access and functional needs are at higher risk and are disproportionately impacted by large disasters. Often they're impacted first and they're impacted worst. And in the US, this group are two to four times more likely to die or sustain a critical injury during a disaster than people without disabilities. So these roles to strengthen planning have a direct impact on helping members live through and survive emergencies and protect their health, their safety, and their independence. Next slide.

So, embedding emergency practices can result in better health and resiliency and health cost savings and decreased use of ambulances, emergency department visits, hospital admissions and readmissions, institutionalizations, and new or worsening or cascading health and behavioral health conditions. Next slide.

So, through Pedro, let's look at these roles. Pedro is an example of a variety of diverse, individual emergency needs. He's a survivor of a mass shooting five years ago, resulting in his quadriplegia. After hearing about a recent, 10-day power outage in another state, he called his case manager to express his fears and ask for some help. He said, if there's a power outage, how would I survive? You know, I depend on power equipment to maintain my independence, to go to college, and hopefully to eventually get a job as a teacher. I'm a wheelchair user. I need a breathing machine. I use a lift to get in and out of bed and to get in and out of my apartment. I

need to use an elevator and a remote front door opener and a remote gate opener. I get 40 hours a week of personal assistance to help with my bathing, dressing, transferring, meal prep, and cleaning. I have no emergency plan or backup power plan. Please help me create something, something that's realistic. So, next slide.

Let's look at three of the many critical member emergency plans discussed in the roadmap I mentioned earlier. The key—so we'll look at helpers, we'll look at evacuations, and we'll look at power needs. The overarching lesson here is: revise any vague questions you might be using in helping members plan. Get rid of the fuzzy questions. You have to really examine the questions you use. Do they lead to specific detailed and real plans? So the standard advice we all hear is, get a kit. Make a plan. Be informed. It's clear, and it's simple, but it's not good enough for the Pedros of the world. People living with disability is all about attention to the details, the complexities, the nitty-gritty aspects linked to diverse functional needs. It's really hearing, seeing, moving, speaking, understanding or remembering. So regarding helpers, the reality is, often, immediately before or after disasters, people, we are on our own, so it's important to map our helpers, to map our mutual aid, and to map our responders. It's not enough to ask Pedro these weak questions: Do you have help or contacts, family, friends for support and care as needed? The stronger question is, do you have or can I help you develop, a helper list? And this will be a list of people who agree to check in with you, are close enough to quickly get to you, Pedro, in minutes. It's not one buddy, because one buddy will never be there when you need them. It's better to have no less than three people on the list. So regarding evacuation, revise a vague question like, can you exit or evacuate your home? Instead, use the stronger scripted question such as, can you exit your home with or without help using each and every exit? Or do exits need power, for example, your garage, or using an elevator? Can you leave the area without help? Can you roll or walk to a vehicle? Can you transfer to a vehicle from your mobility device? Do you have or can you use a backup mobility device that can break down or quickly be lifted into a vehicle? Do you have quick access to dependable transportation? And if yes, let's make a list. Regarding alternative power plans, do you have a backup plan? That's really too vague a question. Help people make a list of the critical life-supporting and life-sustaining equipment. Not the ones that get by for a week or so without power, but the ones that they must have backup power, and then, what will that backup power look like? Are they generators, battery backup power stations, or maybe neighbors who have solar power and solar batteries? And then the question need be, can you operate the backup power equipment with or without assistance? So, next slide.

Why did I mention use of scripts? Because use of thoughtfully constructed questions scripts stop fuzzy planning by incorporating and improving focus on critical and realistic details like just mentioned, and compensating for gaps, inexperience, variable skills, and unreliable memories of the person helping the member. Briefly, here are six additional roles detailed in the role plan. Next slide.

Besides helping with an individual plan, life safety checks are key in addressing and fulfilling identified needs before, during, and after emergencies, particularly when there's no warning, or short-warning events. So are systems in place to quickly identify members needing priority assistance? Is there a system in place that assesses the risk factors and develops and refines a triage process based on profile sorts and flagged questions? You know, your plans have different terms for this, some of you call it triage, risk stratification, or predictive modeling,

whatever, but is it in place? So, also, another key role is, once safety checks are performed or you're hearing for members, you have a way to provide and pay for home delivery of food, water supplies, and medication, and also, debris removal. We never think about this, but clearing critical paths, ramps, sidewalks, shortcuts, can be vital for someone's ability to maintain their independence, and this is not an area that most local governments cover in their immediate debris removal contracts. Next slide.

Another role, preventing and diverting unnecessary and inappropriate institutionalization, which, unfortunately, you know, so commonly happens to people with disabilities during and after emergencies. So, if it happens, also assisting people in transitioning back to their community living environments. Next, building online literacy skills and telehealth readiness for long-term resilience. This means not only offering to help, but providing the help for obtaining, using, and paying for devices and connectivity piece for these devices. Next is navigating the disaster recovery assistance maze. This is massively under-recognized. It's a lengthy case management process involving advocacy and negotiating complex services that often don't accommodate people with disabilities and related needs like accessible communication, housing, and transportation. Next slide.

Developing specific emergency member communications, now I know a lot of you are going to say, no, okay, a lot you will say, this is not in my lane, but if you do have a role in evaluating content beyond 'have a kit, make a plan, get informed', who develops, revises, and updates your health plan emergency member communication content? And this is content developed and revised for relevancy and clarity, understandability, and usefulness involved with target member groups. The content evaluated that's used in outbound calls or call center emergency scripts, are accessibility standards systemically applied for all members, for all the social media and website content used by members, and do you do the analytics in terms of meaningful measures? Do you look at the number of kits, links and views, downloads, and retweets from what is posted? Next slide.

The importance of emergency content that gets posted is often overlooked by health plans. And so here, I offer you just some of the content that is helpful to post, because people don't often think about using their health plan in emergencies, the 24-hour nurse hotline, how to reach their care manager, and many other of the items that are actually listed here. So, next slide.

An overarching role is, this is critical, partnering with government and community organizations to coordinate and force-multiply your support roles, your reach, and your effectiveness in all of the roles that were already mentioned. And this includes contracting with subject matter experts, contracting, for example, with disability-led and disability-focused organizations to help with this time-intensive work. These folks are often best at applying skill sets used in delivery of services rooted in reaching, understanding, and using the details, the diversity, the nuances, the complexity, and the cultural and linguistic aspects of living with a disability. And lastly, applying meaningful measures. Next slide.

Really be thoughtful about what you're doing, and evaluate, evaluate the effectiveness. Evaluate the effectiveness of the scripts you use. Evaluate the impact regarding the increase in number of people who actually have a helper list or a grab-and-go bag or a power plan, power backup plan, evacuation plan, and transportation plans that are real, not based in magical

thinking, but real, and also that have online literacy skills. And also, we often don't think of this but integration of worker emergency competencies. For example, are they represented in employee training in job descriptions and in performance evaluations? So in summary, next slide.

You know, the big change starts with small steps. I think the jargon, unfortunately, says it quite well. Grab that lower-hanging fruit. And, next slide.

Just to really sum it up here. You know, this is about embedding concrete change. It's about really attending to the details of planning with people. And it's about multiplying your reach through contracting and partnering with community organizations and then thinking about, is this working? What are the impacts? What are the outcomes, and what are the meaningful measures? So, I always like to say, you know, the goal is not lessons learned first, it's a term that I often cringe when I hear it. The goal is not just lessons observed, documented, or heard about, but lessons repeatedly applied so that eventually, not in the beginning but eventually, we can claim them as lessons learned. So, those are the key issues I remind you to, you know, think again about, what are you posting on your websites that is helping members think about their planning ahead of time, how they can use their plan, what if they have to go out of network in an emergency, lots of questions that people have in the emergencies. Plans can be very helpful with these really, really tough questions. So, I hope, Laura, I left enough time for questions, and back to you.

Laura Maynard: Thank you so much, June. That's very helpful, useful information, and we got a lot of positive comments in the Q&A in addition to some questions. And we do have time for a couple of questions. One was saying that the examples of rephrasing the emergency plan questions, getting them more detailed, that those examples were just fantastic and much appreciated. And they want to know, how can we support rephrasing questions and writing out very detailed emergency plans? How can we support getting that to happen?

June Isaacson Kailes: Well, it's a great question. And in my experience, I think it involves really, you know, relooking at any software that gets used and helping to refine and revise those fields to include the scripted questions and, when needed, you know, dropdown probes or dropdown questions that go further. You know, in my experience a lot of plans use software for their guides, so that's one way, and then it just takes hard work. It takes hard work to really think through in a workgroup, okay, how could this question be improved on, and then how do we get everyone using, you know, these questions and understanding the intent and the depth of the answers in the plans, so we're looking for, I think the basic question is, a workgroup to evaluate this, do the hard work, you know, test it. Look at your software and revise and reset the questions.

Laura Maynard: Great, thank you. Really good tips. And another question on working with community subject matter experts and community-based organizations. You had mentioned that it's important to contract with those, and a question came in regarding volunteering to do that. Could we partner with them other than contracting with them? Any thoughts on that?

June Isaacson Kailes: Well, you know, one of the things that I think is often overlooked is that few think that nonprofit organizations are charitable organizations, but it's kind of a misleading

tax label, and although, you know, the tax debt is just nonprofit, you know, community organizations are businesses, and they have contractual and financial and compliance and deliverable obligations like all the rest of us. They have payrolls to meet, operating expenses, so many groups do want to be involved, but they've got to have the wherewithal and the staff to pivot and be able to still meet all of those baseline obligations and then do a good job in the roles that we talked about as well. So, that's why contracting is important, and not to always assume that community-based organizations are available to only volunteer their time. I think we really have to look carefully at that.

Laura Maynard: Thank you. Thanks so much, June. And we're out of time for questions right now, and I know a few other questions have come in. So, folks, if you have additional questions for June, continue to put them in the Q&A panel and we will develop a Q&A document following this event that we'll be able to share out with you the responses to some of those other questions. So June, thank you so very much, and at this point, we're going to switch over and introduce from iCircle Sarah Fitzwater, the Director of Clinical Operations, and Samantha Bartz, the Director of Clinical Services. I'll turn it over to you ladies.

Sarah Fitzwater: Good afternoon. This is Sarah Fitzwater. Samantha and I are so excited to share our practices at iCircle with you today. We're joining you from western New York. Next slide, please.

iCircle is a nonprofit Managed Care Organization in New York, and your first thought when you hear New York is probably that big city with lots of lights, when in reality, shift your vision closer to Niagara Falls and think more of the rural areas. We cover 30 counties throughout the state and our agency is relatively small. We actually have 163 employees, with our clinical team making up 62 care managers and only 10 assessment nurses. With this team we support 3,500 members throughout the state, and the majority of them are dually eligible, and that leaves only a small number that are only fee-for-service Medicaid. We assure that our members' access to personalized, life-enriching hometown care for their healthcare and social support needs. Being a smaller agency really allows us to work closely with our members and build unique relationships and perspectives. Next slide, please.

We center the work we do on our members and we have a very robust person-centered service planning process. You can say that we eat, sleep, and breathe person-centered concepts, planning, and actions. And we really pride ourselves on recognizing that our members are going to be the experts on what they need, and it's our role to help support them. So when we're talking about their plans, we're always including the support people that they choose to help them through this process. We look at their person-centered plan at a minimum every six months, but as I mentioned, we have a very specialized relationship between our care managers and our members. A lot of our members have actually been with their care managers for about six years, so you can appreciate that relationship that they've built and how that helps to stay on top of what they need in creating and updating their person-centered service plan. We do this on a more frequent basis, so we have monthly contact with them and it is a breathing, living, changing document that gives us the ability to change it when they call us and say, X, Y, and Z changed in my life, I would like to make this adjustment, or I'm going to need more help in these areas. We spend time going through a risk assessment which includes several key variables including fire safety and evacuation. Looking at their chronic medical condition,

looking at how they're able to travel, is it something that they can do independently, or do they need more supports, what can we do to kind of get through the barriers that may interfere with their ability to travel. Their level of safety awareness and natural disaster preparation. We're constantly focusing on safety. That starts from the time that they enroll with us and it moves through their active enrollment with us. We're doing our best to plan for as many what ifs as possible and, again, just really using our relationships to go through each of these key areas in their risk assessments. Next slide, I'm going to hand it over to Samantha.

Samantha Bartz: Thanks, Sarah. So, our determination and application of our risk score, it really comes down to what June had mentioned earlier, being very specific for the questions that you're asking the member. Both of the things that we consider when determining our risk score are things like their ambulatory status, are they ambulatory, are they able to use a cane or walker, or do they rely on a wheelchair for mobility, and do they have an ability to exit their home in that wheelchair, do they have a ramp, or do they require somebody to assist them out of the home, can they self-propel that wheelchair. Some people still rely on somebody else to assist them with that, and do they have somebody available at all times to help them with that. Other things we consider are life-sustaining medications or equipment. Does the person require tube feeding or suctioning or other equipment that relies on electricity, or a medication that maybe needs to be refrigerated? Things that you want to be very specific with that member to know what their needs are. Something else is cognition, so are they able to even identify that there's an emergency going on? Can they summon help appropriately, or do they have somebody that's able to provide that oversight and supervision for safety changes in the home? Medical fragility, again looking at their complex medical needs, do they have wound care needs or other long-term support needs, and looking at the longevity of different emergency situations, is it a short-term situation where they only need somebody who can come in for day or is it something that they may need somebody longer-term with them. And also, of course, looking at social support, who do they have available to them, what capacity is that person willing to help, and when is that person available to help, analyzing any gaps that you have there. Looking at other social supports that may not be a person, are they able to get food delivery or other community resources that that person might have available to them? And this may seem obvious, but application of that risk score is prioritizing those people that you are reaching out to first, are those who are at highest risk. So, that's going to be fluctuating all the time and should be evaluated frequently based on changes within that member that you are talking about with them and evaluating and updating that emergency plan, and targeting those who have higher risk as reviewing that emergency plan more often with them. Next slide, please.

Our emergency preparedness plan is part of the person-centered service plan that Sarah mentioned earlier. Our plan includes our operating protocols, so this is a very robust document that we review annually as an interdisciplinary team with our medical director, our chief medical officer, utilization quality assurance, our clinical team. We all work very closely on that plan to incorporate anything that we've learned over the year or different things that we may have experienced that could play into this operating protocol. We also have our member risk classification system, so that is based on our UAS-New York assessment, so that's a standardized functional and environmental assessment that we do on our members at least annually or any time that they've had a change in condition. We also have that risk score that we develop based on the factors that I was mentioning the slide before. And, that backup plan.

So that backup plan is of course going to really play into their safety planning if they don't have a very robust backup plan, they may be at higher risk when an emergency does happen. We also use our Social Determinants of Health assessment to assess any potential gaps or increased risk for our members, so, things like food insecurity or housing risk. We want to look at gaps that they may have, because that can be exacerbated in an emergency situation. We also keep a list of telephone numbers for emergencies which we update regularly for all of the counties that we cover, and it covers a wide variety of different emergency services. And for some of our members, we do even register them with local utility companies or emergency services based on their needs. Next slide.

Laura Maynard: Thanks, so much, Sarah and Samantha. Really appreciate that, and we'll have some time a little later in the presentations for some Q&A. So if any participants have a question for iCircle, please go ahead and continue typing those into the Q&A panel and we'll address as many of them as we can a little later on. Now I'm happy to introduce our next speaker, Stephanie Rasmussen. She is the Vice President of Long-Term Services and Supports with Sunflower Health Plan. Stephanie?

Stephanie Rasmussen: Thank you, Laura. Good afternoon, everyone. It's very nice to be able to spend time with you. And I'm coming to you from sunny northeast Kansas today. So, next slide, please.

Sunflower Health Plan is part of Centene Corporation, and Centene is the largest Medicaid managed LTSS health plan in the country. At Sunflower Health Plan, we manage all Medicaid services for approximately 166,000 individuals across Kansas, including medical, behavioral health, and long-term supports and services. We have approximately 11,000 individuals who receive home and community-based services in our health plan, including 5,000 individuals with I/DD that receive HCBS services and another 1,700 that are on a waiting list for HCBS. Approximately 2,000 individuals who are frail and elderly, another 2,100 that have physical disabilities, approximately 200 children and adults with brain injuries, 200 children with technology assistance needs, and we also have a population of individuals that participate in a Kansas Medicaid buy-in program for people with disabilities who are employed or wanting to become employed. We also have smaller Medicare Advantage and D-SNP plans, with the Medicare Advantage plan having about 1,700 members and the D-SNP plan having about 1,870 members. Next slide, please.

Some key considerations for managed health plans that support individuals with disabilities are those who are dually eligible. We feel it's important to facilitate regular communication with our regulators and with key stakeholders, including members and providers and community-based organizations to determine the ongoing barriers that persons who are dually eligible or have disabilities face with being able to access the services they need to live safely and successfully in their communities. We also feel it's important for health plans to reevaluate the tools and methods they use and that are utilized by their providers. Have teams to develop person-centered emergency backup plans and to be able to regularly update those plans as needed. We also feel it's important to have strategic partnerships to be able to acquire and distribute needed equipment and supplies when necessary, and that can be with local providers, but community-based organizations and local nonprofit providers of disability services. It can also be as a health plan using national contracts to procure needed items that maybe local

providers are struggling with getting at a certain moment, and that is one thing we found very valuable in the pandemic was our ability with those national contracts to be able to determine what supplies were available and make our providers aware and our members aware at any given time. We also feel it's important to work with our state and federal regulators to make sure that necessary changes are made to cover benefits, to help individuals to be able to continue to access those services. And that can include making some temporary changes to meet member needs or giving us the opportunity to implement grant-funded or pilot projects to cover those needs. We believe it's important to have resources in place to implement quick changes to covered benefits, so having the staff available and the systems available to get those quick changes implemented so that members are able to continue to get the supports they need. And to have a willingness just to think outside of the box, and to be creative and go beyond traditional standard processes. Next slide, please.

So during the pandemic, some of the things that we saw our members experience was a lack of access to direct caregivers. We saw this at the beginning of the pandemic and we've really just seen the workforce challenges increase since that time. Lack of access to caregivers when planned emergency backup supports were unavailable. At the beginning of the pandemic, we really saw some of our members struggling with getting convenient and easy-to-understand educational materials about COVID-19, to really be able to learn about it and understand how to protect themselves. We definitely saw a lack of access, as you all know, to personal protective equipment and cleaning and sanitizing supplies for both formal and informal caregivers. One of the biggest struggles we saw was for members to self-direct their care, who were used to being able to just go to their local Walmart or their local Dollar General store in Kansas to be able to pick up some gloves or some cleaning supplies because the shelves were empty, and they didn't have the capability to order from larger suppliers like providers would be able to do. We saw challenges with connectivity, equipment, and education or support for using different telehealth platforms, and we saw challenges of course with lack of access to vaccines for participants and their caregivers, either because the vaccines weren't available or the locations were not accessible to them or they didn't have the ability to leave their homes to go get a vaccine, or that there was a requirement for direct caregivers to show proof of employment at one point of time, and there were some challenges with persons who self-directed their care with having, you know, some ability for their employees to be shown, to show, excuse me, that they were employed by someone with a disability to provide services in their home. We also saw a limited ability for individuals to receive needed daily care in a different setting or from fewer people if they wanted to isolate more, to receive extra or needed supports while they are in inpatient setting if they needed to, or to be able to quarantine or isolate while receiving needed daily supports. Next slide, please.

So, some of the strategies that we implemented to address the unique challenges. First of all, we have tried throughout the pandemic to kind of collect the lessons that were learned and make improvements to our person-centered individualized emergency backup plans for members. Each of our members that received home and community-based services does have an individualized backup plan that's developed through their person-centered planning process. So we recognized that prior to the pandemic, we hadn't really helped individuals identify a limited-number group of caregivers that may be able to come and provide care to them that they felt safe with when they preferred to isolate. That wasn't really, you know, a situation that we had thought of that needed to be in the backup plan. We also realized we needed to help identify

additional backups when the primary backup supports were not available or able to be in contact with the member for some reason. And we needed to identify backup locations when services are temporarily closed. We saw a lot of that happening during the pandemic, or when a member didn't feel safe going to their service that they would typically go to, that they needed a different alternative place to receive services. We always recognized the importance of ongoing person-centered discussions with a member and their team so that the backup plan is as thorough and current as possible. And, we continue to recognize, as we did prior to the pandemic, that members can choose to self-direct their care regardless of the support system they have in place. They do have that choice. However, we realized it's also very important to have conversations with the member about having an effective system of backup supports and to kind of talk through some of the things that can happen so that they are prepared and they understand the importance of keeping their plan current. Next slide, please.

To address the issue of the shortage of caregivers as kind of a backup to the backup plan, we did implement an emergency backup service pilot in late 2020. We offered a \$100,000 grant through Centers for Independent Living, and we had them give us proposals for how they could implement an emergency backup worker service system for people that self-direct their care. And again, this is kind of a backup to the backup plan, so when an individual's backup plan supports are not available that they would have some, a place they could call to have a worker come and be able to provide the support they need. We did receive proposals from different Centers for Independent Living, and we chose two that offered the services in three counties. One of the counties was urban and two were rural, so we can take a look at the impact in those different types of situations. These Centers for Independent Living worked with our care coordination team to educate members in those counties who self-direct their care on the availability of the service and on how to access it. And then they deployed an on-call, direct-care workforce to offer backup support when the member needed it. Next slide, please.

We also implemented in April of 2020 and we continue to have provider-level virtual meetings with our LTSS stakeholder groups, so we have a meeting every two weeks on Fridays for an hour with all of our LTSS provider associations, member advocacy groups, and our state regulators, as well as the other managed care organizations in Kansas, to continue to collaborate and share information on what the changing needs are of members with, living in the community. We feel like that regular communication is very valuable to continue to identify the changing barriers that our members are facing, to discuss potential solutions, and through these stakeholder calls, we've been able to develop strategic partnerships between the states and managed care organizations, providers, and others to deploy PPE, to make the needed changes to our benefit packages, for our strategies from meeting with members, and other things needed to do to continue to support our members in the way that they need. Next slide, please.

We also started in March of 2020 remote care coordination visits with our members to continue, to complete their assessments, make sure their service plans are up to date, to hold person-centered planning meetings, and to do those regular touch-bases with members that they need. Many of our members in home and community-based services do face challenges with access to video conferencing. In our survey in 2021 showed about one third of our members are comfortable with using telecommunication for remote visits. So, we really still kind of struggle with people having access to the technology they need and the connectivity to be able to do more than a phone call and have video visits. Fortunately, we are back out in the field and able

to see our members, at the choice of the member. They still have the ability to request to meet remotely if they're more comfortable with that. Next slide, please.

We also worked with our state regulators on some flexible options through an Appendix K for I/DD home and community-based services. We did see several day service providers, a majority of day service providers, close or reduce their census during the pandemic just for safety purposes. So, we work with the state to offer the capability of assisting individuals with receiving I/DD day services in a home or a residential setting, or even virtually if they were able to participate in day services through a virtual platform. We also worked with them to offer the ability for individuals with I/DD to receive paid personal care services from family members in situations where previously they weren't able to do that to get home-delivered meals, which is not part of our Kansas I/DD waiver benefit package. We were able to cover those, as well as some additional assistive services, and for individuals to receive home and community-based services while they were in an inpatient hospital setting if they needed those services to be able to participate in their care while in the hospital. We educated our members with I/DD about those new options through telephonic contact and outreach through our care coordinators as well as through our provider network and member advocate network. Next slide, please.

We further worked with the state to make some changes to other home and community-based service programs for seniors and other persons with disabilities to again be able to pay family members who were previously prohibited from being paid caregivers, for those family members to be exempt from the requirement of having to use the electronic verification system, at least temporarily so we could get them started and get them paid. We also were able to offer to others besides persons with I/DD HCBS services while in a hospital setting, and that individuals on a brain injury waiver can get their extended therapy services through a telehealth option instead of being required to receive the services in their home. And again, we educated our members about those options through our care coordination contacts. So, thank you.

Laura Maynard: Thanks so much, Stephanie. We really appreciate all that great information.

And if people have questions for Stephanie, please just type them into the Q&A box and we'll get to those a little bit later.

Now I'm happy to introduce Merrill Friedman and Christina Mills. Merrill is the RVP of the Inclusive Policy and Advocacy area at Elevance Health, and Christina is the Senior Director of that area at Elevance Health. So Merrill and Christina, I'll turn it over to you.

Merrill Friedman: Great. Thank you so much, Laura, and we're excited to be here today. I appreciate the opportunity of this discussion and all the information, so honored to be part of the panel. People are doing, plans are doing really great work. I'm calling in from DC. Christina is going to be on in a minute, and she's calling in from California, but she will share that as well. So the good thing is when you go last in a panel like this, so much good information has been shared, and there are a lot of similarities. We can go to the next slide, please. Thank you.

And also, my computer crashed in the middle of all this, and it gave me time to actually reboot and be prepared, but I had a backup plan which is what this is all about, so I have my iPad

handy so we would've been ready to roll anyway. So, good panic moment, my heart is absolutely beating. But, you know, we have the pleasure of working for Elevance Health. What you're going to hear about as we talk about the work that we have done in communities to support people is working with community organizations and independent living centers and triple As, which is where Christina comes into the picture, where we partnered with Christina when she was at the California Foundation for Independent Living Centers and with all good fortune is now working here at Elevance Health, so helping more from the inside as well as the partnerships. So it truly does come full circle when the plan is aligned, so very fortunate. Elevance Health is also a healthcare company. We are a healthcare partner. We are an insurer like our friends at Centene and work very closely with organizations in supporting people in their communities, so individuals, families, providers, the full network, and helping, right, to blend all that and bring it together to connect people to the resources that they need so they can live healthy and well lives in the community based on their terms and their goals. We serve about 118 million people through multiple lines of business across Elevance Health. Some of you may know that we were formerly Anthem and changed our name earlier this year to Elevance Health, which was a mix of elevating and advancing health to actually be able to sort of move through a cultural transformation to be more present in cultural communities and to look beyond our traditional healthcare services, so one in eight Americans are served by Elevance Health or one of our lines of business. We do have 25 locations with Medicare and Medicaid in the states, DC, and Puerto Rico, and as you can see here, we have 10 million Medicaid members and 2.8 million Medicare members. And yes, because I just saw this pop over there, when we get to ours too, I/DD is intellectual and developmental disability, so, next slide, please. Just to answer questions while we go along.

This is our footprint. In the interest of time, since this is going to go out, and you can find this on the Elevance Health website, I won't go into this, but we do appreciate the opportunity and are very privileged to serve people in the states across the country. Next slide, please.

Right, so here's where we get to talk about some of the fun stuff that's already been talked about, and that's the work that we get to do with people every day. Our service coordinators and care coordinators and care managers are on the phone daily working with people with disabilities and older adults as well as many other individuals, and really constantly talking about what are our backup plans, who's there to support you? Particularly through the pandemic, I think we learned a lot more about how we can support people as their supports changed almost daily. And so I think that's really important that we keep that in our minds as we go through our emergency preparedness work is that it changes all the time. Connecting people to community resources in advance, helping people to be aware of what those resources are. I think Christina and I learned early on, and June was, you know, part of many of these processes as well, that people don't necessarily know where to go in the event of an emergency. Is it accessible? Can they get there? Who's their support person? And is that support person, like me, my support person would be identified as my husband, but there's a good chance at the time of an emergency, I may not be near him. We may not be together. So how do we kind of build our pod and help people build their pods and have that access to those community resources? We heard June talk about people who would be institutionalized during emergencies, and we worked very hard and put out a lot of statements as well to do everything we can to support people in their own communities at the time so people don't end up in institutions and people don't get sent out of state. And we saw a lot of that during Hurricane

Harvey and a couple of other emergencies where people were sent out of state and then getting home is not easy. So preventing all of those disruptions and helping people get that access very close and near to them, to where their comfort zones are and their people are. We will talk a lot about these functional support needs, but they have been talked about already. So do people have access to other backup power resources and the health supplies and the transportation? You know, people who are on dialysis, do we have access to dialysis? We get very nervous after about 24 hours when people don't have access to dialysis, medications, power, mobility aids. So it is very important that we are constantly updating and upgrading what we're doing to support people throughout emergencies, and Christina's going to talk because she brought up a really good point as well, is that emergencies aren't just, you know, big disasters. There are a lot of other emergencies that happen and crises, if you will, that happen within people's lives that are as disruptive, and so it's every person individually throughout the year, not just when there's a fire or in a tornado or during a derecho and other, you know, emergencies, there were the floods in eastern Kentucky, there's plenty more. So these evacuation plans that are fully accessible and planned out and have lots of different resources aligned to them are most important. Next slide, please.

So, Christina, do you want to jump in here?

Christina Mills: Thank you, Merrill. Thank you, Merrill, and thank you, Laura, for inviting us, and Stephanie really made that point about emergency preparedness being so much more than disasters simply because of your slide. It was a good reminder of all the things we learned throughout the COVID-19 pandemic and all of the ways that emergencies really impacted people with disabilities and those with access and functional needs. As Merrill stated, I recently joined Elevance Health and I'm the former executive director of the California Foundation for Independent Living Centers, which served as the association working on public policy on behalf of the centers in California. I think one of the most important things to really start off the conversation when we get into power outages, is that at the beginning of the pandemic was also the beginning of California's proactive approach to starting what is known now as public safety power shutoff. So it was an interesting time to be at the foundation and having a pandemic but also implementing California's first cross-disability disaster program specifically aimed towards ensuring folks with disabilities, older adults with electricity needs, anybody who used essentially durable medical equipment or assistive technology that required electricity and being supported with backup power in some way, shape, or form, whether that be through a portable backup battery or moving that individual and covering the transportation cost needed to get someone into an accessible hotel or lodging space, in addition to getting back home and covering their food needs as they were out of their home. One of the important points I want to cover in that is, that really wouldn't have been possible had we not had the seed money from Elevance Health, Anthem at that point, to really see if portable backup batteries were a solution for some people. And I say some people in capitals, because backup portable batteries do not work for everyone, but we have found in California over the last few years that especially those who use CPAP machines, those who use nebulizers, other types of breathing apparatuses, not oxygen by any means, can, can rely on a backup power source for a day or two but not much longer than that, and if you're in California like me, you know that depending on where you are in the state, public power safety shutoffs can last more than a couple of days unfortunately in some sense, and the fact of the matter is that whether it's a public safety power shutoff, or a brownout, or a winter storm, or a car accident that takes out the power lines, people with

disabilities and those with access and functional needs that rely on electricity need backup electricity sources, and we found in 2019 that because those sources were not available, many people, of course, what did they do? Call 911 or go to the emergency room when they do not have those things in place. So, I cannot say how important it is over and over again to really, really work with members and consumers to constantly update that emergency preparedness plan. And I have had the great fortune of working with June for many years, and I see her as one of my mentors in this area especially, but also Richard Devylder, and one of the things Richard Devylder, who was the first Office of Emergency Services access and functional needs director in California, had said was, if you rely on somebody else during a disaster to come and get you, good luck. Good luck with that, and what his point was is we all need to be prepared to plan and take care of ourselves and be as proactive as we can and resilient because we never know, we never know what may happen and how we might be impacted, and so that was one of the main reasons why we pushed back so hard and continue to push back on any type of formalized registry because it oftentimes, and I've seen it happen, unfortunately, where people think that because they signed up for a registry, that that means somebody else is going to come get them, and we've simply seen that isn't the case. And we've lost lives as a result. But having a health plan really go through, and I was texting June while she was talking so she missed it, but one of the things she's always said to me in the preparedness component of what we did in California was, we need to make sure that we're asking people as we walk through what their preparedness plan looks like, what does your day look like from the point that you wake up to the time you go to bed? And that can change, right? It can change like it just changed for me when my son went back to school. My day looks very different now compared to what it looked like during summer break, so, again, that's why it's so important to check up and see what's changed in your plan, it can change at any given time. But power outages, cooling and heating centers, knowing where those are, knowing how to provide temporary lodging, and one of the things that we found in the temporary lodging piece that was really important is knowing which lodging options allow you to bring your pet. I cannot tell you how many people don't want to leave home without their pets, so one of our outcomes in California was to ensure we had a contract with a lodging facility that would allow more than service animals, but actual pets too. So we had a couple of different choices when it came to putting people up in different hotels and motels. Being able to access food and replenish spoiled food from power outages and any other type of emergency or disaster, and then having accessible, affordable, reliable transportation and gas support. So lots of times we found, and more frequently than not, I was really surprised, that people might have been able to get their own transportation to get to that hotel or get to a warming or cooling center, but they really needed gas resources to make that happen. So again, that was one of the ways in my former position, that Elevance Health was able to support Californians in providing gas cards to make sure people got their needs met. And then having backup power sources and points of contact for support, and that one, you know, as a person with a disability myself, that's been a discussion that has been difficult because some people are okay having many people in their circle and some people are less comfortable with that, so, just making sure that you're really being sensitive to the person's needs. Next slide.

All right. Now, one of the things I want to cover that's really important, and June brought it up as well, is bringing in the expertise of people with disabilities and those with lived experience that can really walk the walk and talk the talk to help somebody in preparing. And making sure that you understand that a one-size-fits-all model does not work for our community. I don't

know that it works for any community, frankly, so really taking the time and having the patience to understand what somebody's emergency preparedness needs really are is hugely important. Having the patience and having somebody with the ability to relate to another individual is incredibly helpful. And it brings up things that a lot of people don't necessarily think about but really makes them feel more comfortable in diving deep on, like whether or not they need catheter supplies more frequently during a disaster because they don't know when their next prescription will arrive, things of that nature. Being able to provide resources and suggestions based on your own lived experience and being a trusted, go-to partner is key. Next slide.

Access and functional needs disaster or emergency considerations that I would strongly suggest everybody consider is, what alert and notification systems exist in your community. I know I've gotten some FEMA alerts today while we've been here. There's going to be some flash flooding in San Diego apparently today, but looking to see what kind of notification systems exist, from local to national to statewide, but figuring out which of those are accessible as well. And that is the key. A lot of times there are alert systems in place, but they might not be as accessible, and I cannot underestimate the power of social media. Lots of people, billions of people are using social media. If we can get emergency response agencies to—and ourselves—to use social media as a way to communicate how you can support, what's going on in the community, and things that might be of resources to community members impacted. Using social media to do that is wonderful. My only thing is that it's really hard if that's only available Monday through Friday, 8:00 to 5:00. Disasters and emergencies happen at all times. Having long- and short-term disaster and emergency planning tools is also maybe something that you want to consider. We found that some people don't have the time or want to take the time to do a long, drawn-out plan, but are willing to do a short-term plan. And that works for folks. That's great, and oftentimes when the short-term plan has been used, people will come back and say, I want to do the long-term plan, I get why I need this, it was helpful. And just the more thorough, the better. Thinking it through, making sure that your member understands who they can call, when they can call, what's going to happen when they call. And then plans should be always as individualized as possible, and there's a lot of templates out there to get you started, from the Red Cross, from FEMA, from other organizations, but I would really, really encourage everybody to build on those plans based on the individual's needs and their disaster or emergency, not based on their geographic area. Next slide.

Laura Maynard: All right. Thank you so much, Christina and Merrill. Appreciate that presentation, and we're going to go into a panel discussion format at this point, and I know we've had a few questions come in. We may try to work some of those into the panel as well, and very honestly, because in the interest of time, I'm going to jump us to the last question first, just in the interest of time, to make sure that we're able to cover this one. So just giving our panelists a heads-up, I'm jumping over now to the last question first. And this one is, how do you involve members in developing the risk assessment and those person-centered emergency plans? How do you involve your members in that? So first I'll call on, let's see, Christina and Merrill. Could you speak to that one?

Christina Mills: Go for it, Merrill.

Merrill Friedman: Sure. So, you know, we, our service coordinators work directly with members. Anybody that's a member wants to bring into the conversation, that's part of them, great, and so we just get right into it and talk about, you know, where they live and how they live and what's important to them, what's going to be important to them and what are those crisis points and access points and resources that they will need, you know, throughout an emergency, and then how do we connect to those. So it's just, it's like there's no moving forward with anything without the member being just directly involved. So it just starts with them.

Laura Maynard: And you had mentioned, too, a very interesting point that I'm going to follow up a question on, and that is that people who haven't experienced a disaster themselves may hesitate to invest their time in planning their own emergency plan. How have you all addressed that?

Merrill Friedman: Motivational interview. Go ahead, Christina.

Christina Mills: Yeah. Sorry. So, Laura, in the case of folks coming to CFILC, and of course we were contracted with Elevance Health to provide some disaster services, if they wanted to be eligible for resources such as the backup battery or lodging or the things that we were offering that they may need in a disaster, they needed to at least commit to doing the short version of the disaster plan so that we would have something in place, they would have something in place, but it was sort of like the carrot and the stick.

Laura Maynard: Awesome. So to access the resources, you sort of required that they do the shorter version of the plan at the very least, and then others that were more invested, they could do the longer version of that plan.

Christina Mills: Yes, absolutely.

Laura Maynard: Great, thank you.

Merrill Friedman: Yes, and we just, there's no way to not, we really just, we have to get people on this. It's like having long-term care insurance, right? We never want to get, you know, insurance unless there's a crisis and you need it, so we just have to, we have to make the point and make it work.

Laura Maynard: Excellent, thank you. And Stephanie, I'm going to call on you to answer this one from the perspective of Sunflower Health. How do you involve members in developing their risk assessments and their person-centered emergency plan?

Stephanie Rasmussen: Yeah, thank you. It's in a very similar way through our person-centered planning process with each member. We take a look at their emergency backup support needs and develop with them and with their team their plan, and then throughout the year with our regular contacts with the member, we continue to ask whether those emergency backup supports are still available, are there any updates that they want to make to the plan, and we use person-centered thinking, training, concepts with our care coordination team to help them know how to have those conversations and, you know, to your earlier point, you know, what do you do if the member says I don't need an emergency backup plan or I don't want to engage in this

conversation? Ultimately, in Kansas it's a requirement, a provision in HCBS services, but before we get to that with a member, we usually like to at least share examples of why they might need a plan and share life examples of when a plan has benefited someone else in HCBS services.

Laura Maynard: Excellent. Sharing those examples, that's great. And Sarah and Samantha, from iCircle's perspective, how do you involve members in developing the plans?

Sarah Fitzwater: It really starts with those care manager member conversations because the members are going to be the ones that are driving that for us. So having those discussions frequently, often revising them, changing them to stay on top of any unique things that are happening for them because we want to be as proactive as possible with them. There's nothing worse than being put in a situation where you're reacting, you don't know a particular detail of a situation, so really getting creative with them and helping them think outside the box, but letting the members be the driver of what they ultimately want while we provide the tools to say perhaps there's somebody you haven't thought of before or trying to come about it in a different way that they haven't necessarily thought of before. So it's a very unique, collaborative process together with the member driving it and the care manager supporting it the whole way.

Laura Maynard: Excellent. Thank you so much. And we did have one question come in, and I'm going to ask that to all of you. It's a very simple one basically, but do you include emergency preparedness planning in your member handbooks? Is there anything about preparing for emergencies in your handbooks for members? And Christina or Merrill, do you have anything in your handbook about it?

Merrill Friedman: Yes. The quick answer is yes, so we do guide people through the member handbook.

Laura Maynard: And Stephanie, does Sunflower have that as well?

Stephanie Rasmussen: We do have it in our handbook. There's also a more thorough conversation with the member during that initial visit about what that actually means, so, but yes.

Laura Maynard: Great. And iCircle, do you all include it in your handbook as well?

Sarah Fitzwater: We actually do not in the specific sense of the emergency preparedness plan. We do go through that person-centered service plan which encompasses the emergency plan, but I think that's a great idea that we're going to actually move forward with calling out in our member handbook in the future.

Laura Maynard: Great, thank you so much. And, thanks, everybody. Thank you, presenters, for sharing all of that rich information. We really, really appreciate hearing it. The video replay of this and a slide presentation will be available at resourcesforintegratedcare.com. If you've got questions about it, you can email RIC, Resources for Integrated Care, RIC@lewin.com, or follow us on Twitter.

Your feedback matters, so those of you that have hung in here with us through the presentations and the Q&A and the panel, please take a moment to respond to our evaluation form. It'll pop up on your screen shortly after the conclusion of the webinar, and there's a link as well if you would like to provide suggestions on the development of potential other resources.

We have some resources listed at the end of the slide deck that's available for you to download. Many good resources on this topic are listed here, as well as a whole page of resources specifically from June Kailes. So I want to thank our presenters. Thank you, June. Thank you, Stephanie. Thank you, Sarah and Samantha. Thank you, Christina and Merrill. Wonderful presentations, great information. And I'd like to thank all of our presenters for being with us and all of you for participating today. Thanks very much. This concludes our webinar.