

Wednesday, July 25, 2018

MLTSS for People with Intellectual and Developmental Disabilities: Strategies for Success

Please stand by for real time captions.

Good afternoon. This is Erica. I'm with the HCBS Business Acumen Center. I would like to thank you all for joining today's webinar. MLTSS for People with Intellectual and Developmental Disabilities: strategies for success. This webinar is presented to the business acumen center. A part of the grant managed by NASUAD. Shortly after today's session you will be able to find the PowerPoint and the recording of this webinar along with archives of all of the HCBS webinars. There will be time for Q&A at the end of the presentation. These and your questions in the Q&A box in the lower right-hand corner of your screen. Today speakers are Camille Dobson, NASUAD Deputy Executive Director and Laura Vegas, NASDDDS Director of MCO Business Acumen. They will describe the lifecycle phases of a MLTSS program. These phases and successful practices are described in detail in the co-author report MLTSS for people with intellectual and developmental disabilities. I will hand the webinar over to Camille and Laura.

Thank you, this is Laura. It is the National Association of State Directors for Developmental Disability Services. Our association consists of members from each of the state agencies that provide services for people with intellectual and developmental disabilities. Our role is to help advocate for these state agencies and help them learn about best practices, promising practices to help them stay innovative and support them in improving their service delivery system. We were really excited about this paper and some of the things we found as we put together. I am looking forward to sharing with you some of the things that we learned as we spoke to states across the country. MLTSS for people with intellectual and developmental disabilities strategies for success. MLTSS, the reason we developed this paper and take a look at the services across the nation is because there are very few programs that serve people with I/DD across the country outside of their healthcare. There are states that already have MLTSS programs for older adults and people with disabilities and they have been successful in that model. They are looking to expand and create programs for people in their state with intellectual and developmental disabilities. There is some concern and people need more information and that is coming from participants and their families about how managed-care what impact their lives. We found there was very little written about this topic. States, health plans and people who use services and other stakeholders are always looking for promising practices from state who are already operating MLTSS I/DD programs. We partnered with NASUAD and Ari Ne'eman to develop this paper. Ari Ne'eman represents an advocacy organization. We really appreciated what he found. We talked to several state who are already in a MLTSS situation. To understand services for people with I/DD you have to understand the history of I/DD advocacy and how it has impacted the evolution of services. Prior to the 1940s and 50s people with disabilities were basically taken out of society. They were either in prison, some recognized that and help

them move from prison in two state hospitals but there were not any formal supports for people with intellectual and developmental disabilities. Parents decided that their son or daughter's needed better. They had a different vision. They wanted a different lifestyle and a different future for their son and daughters. In the late 40s to mid-50s the whole parent movement began. They begin to question the wisdom of institutionalization. They were questioning if it was best to take people away from their families and their communities and isolate them from greater society.

In the 1950s a small independent group of parents coalesced and started having a voice. Their voice demanded services for their sons and daughters outside of the at regional setting. -- The institutional setting. Advocacy groups similar to that group spring up across the country. The first one was called the National Association for Retarded Children. We know that as the ARC. Those were brought about by a group of parents getting together and deciding that they wanted a different life for their son and daughter. In the 70s and 80s there was a lot of work done at the federal level including some significant legislation. We started looking at providing services to the community with home and committee based services. The federal IDEA act was passed. They got opportunities for the same education and then section 1915 C of the social security act was enacted which allowed services to be provided in the community and in people's homes. Or gone was the first state that received approval for the services.

In the mid-80s and mid-90s the deinstitutionalization trend began in they rebalanced the system. We were looking at providing services to people to help them become more independent and part of their community. We were looking at things like day habilitation and supported employment. We were really looking for a way to help people have better lives instead of just keeping them away and making sure they were only safe instead of looking for ways to improve the quality of life. In the 80s a growing number of people with I/DD made lives for themselves outside of institutions, many worked to form self advocacy organizations run by and for people with I/DD themselves. If you think about a lot of the work that has taken place it is because of the voice of the people that use those services and the things they expect.

I sell that to say you really cannot think about designing any kind of support and service program for people with I/DD unless you make sure that families and the people themselves are at the table and are a real contributor to the design. Parents and families have been pandas for progress for decades and continue to do so because of them people with I/DD are now living in their homes and communities, the institutional opsin is not the first thing they think about anymore. They think about how they can support them at home and in the community. Institutions are closing across the nation. Several states no longer have large institutions for people with intellectual and developmental disabilities. There have been a lot of services and supports developed specifically to support them in their homes, their family homes. Supports and services are designed to support families. There has been a lot of work because of the advocacy movement for self-determination where people make real decisions about their lives and they decide what their goals are going to be and how their dollars -- service dollars are going to be spent. Advocacy is help them -- helped us understand how employment is so important. In all states it has been

instrumental in the development of publicly financed human services system. They bring to the table the expertise , the experience of living the life , the passion that we all need to fill in the express have over the life them and of course love for the person in their family. The voice of the self advocates and parents are just as vital today as they were the 1950s. Their knowledge and wisdom has to be the foundation of any I/DD service model design. It is very important to remember the history and the pioneers of the system. We talk about managed long-term services and support or MLTSS. That is just the delivery of long-term services and supports both state plan or waiver or both three capitated Medicaid managed care plan. Plans can be managed-care organizations , prepaid inpatient health plans, or a prepaid ambulatory health plan it all depends on the scope of benefits provided. Every state is very different in their approach using MLTSS for people with intellectual and develop mental disabilities.

In many cases plans are also covering medical expenses in providing a more comprehensive service delivery system for people with intellectual and develop mental disabilities with more effective coordination of services. As you can see by this map as of July 2018 there is MLTSS in 23 states. That does not mean that that is for people with intellectual development of disability in the states. There is some form in all of the colored states. There are some states that have it in development , Arkansas is in the middle of implementing MLTSS for their I/DD services and we have Nevada, Nebraska and Oklahoma who are considering taking an approach to providing MLTSS in the future. Why would states want to implement MLTSS? We could use that as a model to provide support and services.

Part of the reason is the accountability rest with a single entity. When a health plan there is financial risk and they have opportunities to incentivize and penalize performance of providers in ways that state agencies historically have not been able to do. They can also integrate sideload streams of care more effectively. You can have coordination of your long-term services, behavioral and medical support under one plan and one plan being responsible for the effective coordination and implementation of those services. It is simpler for states administratively to contract with individual health plans , managed-care entities versus contracting with hundreds of thousands of providers sometimes. The managed-care plans take on the responsibility of claims payment, member management , utilization review and simple phase a lot of the administrative burden that state agencies have had on them in the past. MLTSS is also very helpful when it comes to budget predict ability. Capitated payments greatly minimize unanticipated spending. We can more accurately project costs especially with LTSS as a role but does not have much variation based on economic circumstances. The capitated payment arrangement with health plans administrating help states being better able to predict the budget in the future.

People are using MLTSS to shift services to community settings. Most everyone who receives services that is their preference, community based services. Health plans have historically been able to demonstrate effectiveness in diverting and reduced in institutional stays . They have been pretty effective in helping people stay in their communities

and out of the institutions. With the demonstration labors that a lot of states use to provide MLTSS or managed-care entities, they can be more flexible in delivering services. They're not bound by some of the bureaucratic regulation and constraints that a lot of state agencies have to deal with. If we had at the national company they often bring their expertise and experience from other states to the new state that is in development. It is a great opportunity to learn from other states and apply those things that are learned from other states. Local plans are grounded in their community. We have a lot of local plans that are homegrown and started out as a small organization and they are very connected to their communities and have a real investment in the people that live there in making sure their supports and services are quality. There is an opportunity to demonstrate improvement in quality outcome using the HEDIS measures over the FFS. To think outside the box and try different things to improve quality under MLTSS. The person becomes the center, not their services. Long-term service and support can lower acute care costs and increases the likelihood of bending the cost curve. The person is the driver of their services and that helps with better coronation and it lowers the acute care cost people

--. We talked about MLTSS for people with I/DD both programs -- most MLTSS programs include HCBS services for older adults and persons with physical disabilities. If people with I/DD are included is typically only for their medical service. There are eight states that include waiver services for people with I/DD in their MLTSS programs. Arizona was the first state to try MLTSS for people with I/DD and then we have Iowa, Kansas, Tennessee, New York which is looking at broadening their MLTSS arrangement right now. They are doing a financial alignment demonstration. We also have Michigan and North Carolina that also provide MLTSS for people with I/DD. Is continuing to grow. We wanted to share with the public at large some of the great things we found that were going on and states that do provide services and supports through MLTSS. Thank you. Over To Camille.

>> Examples for states contemplating a new or expanded MLTSS program for people with I/DD as well as people for plans that serve consumers as ways to be innovative. The core part of the paper is really taking the program lifecycle that you see on the slide and looking at each of those phases with unique approaches that you need to serve. This is universal across the MLTSS spectrum. I would say for any managed-care program. We have actually taking a land around what states and plans need to do. This is specifically to address the concerns that Laura so eloquently explained, the fears and concerns found on both consumers family members as well as providers. Can you go back for a second? The lifecycle phases are critical. What we have in the middle of the diagram are to that are part of all of the phases, adequate planning time and stakeholder engagement with priority on consumers and families. We'll talk about why those are overarching priorities that the state should keep top of mind as they move forward with the MLTSS program. Adequate planning time. It is critical for success. Any program needs time because of the change it represents to everyone who currently is getting Medicaid services. CMS has recommended a two-year planning process and that sounds about right. Ideally for the type of engagement and thoughtful program design that the partners need to undertake. It gives you time to be thoughtful about the design of the program it

allows the state to develop and identify and implement a smooth transition . Critically provides time to educate both people with I/DD , their families and their providers about what MLTSS means and what it means to them. And allows the health plans time to familiarize themselves with LTSS and how it is different .

Providers in the I/DD space only provide services to Medicaid and so they may in fact need more time to adjust to the requirements that we would put on them for a network anticipation. We have a couple of examples. We will talk about each of the elements and try provide specific examples that are outlined in the paper the examples we provide are not exhaustive. We have more that we pulled out a sample just to give you a taste of the kind of efforts that the states and plans are making. For adequate planning time I think the model right now across the country is Tennessee. They spent more than two years in planning their MLTSS program for people with I/DD called for people with I/DD called employment and community first choices program. Tennessee has had MLTSS since 2010.

They were very thoughtful and deliberate about the designing of programs with a separate name, separate requirements for the program. It is a good example. Wisconsin has been doing something around their family care program which is integrated the MLTSS program. They have expanded over the last 10 or 15 years by County. That has allowed each area of the state to really get used to the managed-care program . Stakeholder engagement cuts across all phases of the lifecycle. It ought to be broad-based and bilateral. By that I mean not just speaking to advocates , providers, health plans, community based and anyone who has a vested interest in a successful service delivery system for people with I/DD. It is not enough to just listen. What we found for states that have been successful they have actually taken feedback during the planning and design process and during the implementation and process and the feedback of consumers, family members, providers and their plans all of the stakeholders and tweaking and modifying their programs as they go on. It is really important that it is a two-way street and not really just having a stakeholder engagement for the purposes of saying you have a stakeholder engagement. One of the things that I think matters in a handful states is actually helping somebody get families and providers understand how to engage in making it easy for feedback to be provided and not just having a small community meeting. That is critical. Next page.

Not just to the state itself but once the program is implemented requiring the health plans to have a process to get input on the way they are operating. Plans are required to have consumer advisory councils or some kind of member committee of some sort. Recognizing and incorporating people with I/DD and the family members with each of those existing committees is really important so that the voice of that part of the population does not get lost. I didn't talk about families and caregivers and members in the prior slide but they should get particular attention for all of the reasons that Laura identified early on. We wanted to make it clear that the history and advocacy in this area and the push for self-determination is a really critical element in the delivery of services for people with I/DD and it is frightening, the changes frightening. In making the consumers of family members about the plan of what the state is thinking about is critical. Being

transparent and engaged with stakeholders not just taking in feedback but actually responding to the feedback that is provided. Adequate time to look at successes and failures and how can be improved. It should be ongoing and not just during design and up limitation.

Back to Tennessee. There program was built jointly between the Medicaid agency and there the mental disability agency who held joint in person meetings with provider and advocacy groups, community meetings and public feedback meetings across the state and provided access online to a survey to provide feedback. All of that feedback was incorporated into the program design. North Carolina which is imminently going to be lodging a MLTSS program hosted listening sessions across the state, invited written comments and did targeted outreach to consumers, their families and providers. While North Carolina doesn't have a program with I/DD their larger program that they are intending to launch will have a lot of interaction and will impact. In Kansas sunflower health plan early on hired a LTSS manager with experience in serving I/DD and was a critical part of the development of the MLTSS program especially core services with people with I/DD. With those overarching excess of a good strong MLTSS program so to take care of let's focus on the specific areas of the lifecycle.

The first is goal identification. Why are you doing MLTSS? Talk about the reasons the states pursue the MLTSS that Laura went over earlier, some of those are relevant for people with I/DD, some of them are not that I highlighted here. Most states want to continue the key positive elements which are focusing on person centeredness, providing as many employment choices and maintaining self-determination for individuals and their families. Today the I/DD system is generally mostly rebalanced and that means most individuals and most dates are being served in the community setting. They are not residing in an institutional setting. That goal we talked about, shifting care from institutional to the committee setting typically does not apply. There have to be other goals. Some of the ones we have heard are improving access to preventative and acute care services, where individuals with I/DD may often be underserved. Providing conference of care and service coronation between acute services. In many states they want to have budget predictability and stability for the MLTSS expenditures. They want to be better able to project their expenses for the services. Into specific examples, and Michigan and Tennessee. Both states said one of the primary goals of the program was to increase access to competitive employment. That is an area of great focus for most states that have MLTSS programs but it helps to make it clear. Setting a goal up front and on purpose allows all of the parties engaged to really understand and focus their attention on those stated goals. It is clear and effective medication which I think is important.

In addition to employment Tennessee did focus on a secondary goal of making community living the first the preferred option for people with I/DD. Individuals coming into the system to ensure that it was community first, that is for food -- pursued first. Once you have goals this key part is program design. Many state, some of the decisions they need to make have considerations larger than just the program and their specific needs. States need to understand their FFS

costs, utilization and have a really good sense of what their current fee-for-service system looks like. They need understand the cost of providing services, and what kind of services they are providing. All that needs to be really clear before moving that into a mainstream delivery system. To particular pieces are setting adequate capitation rate so they have enough funding to adequately provide services and particularly for states providing different services than they currently provide. Identify network capacity, making sure there is enough network access and identifying gaps. If the state wants to pursue a different type of service arrangement they know very clearly where really have adequate capacity and where the plans will need to work on building capacity. The populations to be included, benefits included and where in the state the program covers will need to be identified.

States will put out a contact paper of some sort to explain the design and the right feedback. The state needs to decide on what authority they can get from HCBS. They will need to determine that and go through the process of getting approval from CMS. They also need to make sure they do not lose the infrastructure they already half. All but a handful states currently undertake the national core indicators survey and provides lots of rich historical data of these individuals with I/DD. I think it is important that the state not stop that moving to a managed care program. We can highlight in Kansas in particular has made a conscious effort to continue to administer the NCI survey to individuals. Requires health plans to use the data about what they are saying about the quality improvement activities. They were to be sure they are addressing it.

The second pieces state infrastructure. Not a lot of people pay it into this but moving from a fee-for-service they need to move providing case management. The quality oversight has been at the provider level. Switching that around to a managed care oversight where some of those direct activities with providers and members will be removed and it really becomes about oversight of the health plans and broad policy requirements it really requires the states to be thoughtful about how they engage expertise across the system. In many states I/DD services are being delivered by an agency other than the Medicaid agency which is getting federal funding from CMS. It is really important for the Medicaid agency, collaborate with the I/DD agency to make sure they have pulled on the knowledge and experience of those individuals for the design implementation. In this area in particular we have agency as well as education agencies play important roles for children transitioning out of the education system and appointment opportunities. It is a broader array of engagement across the state that would typically be for a different kind of MLTSS program. The staff that had been overseeing the system have a lot of experience. You do not want to lose that. They should find ways to engage the oversight staff in quality monitoring of the -- at the health plan level. They need to bring their expertise and incident reporting and provider oversight that they have been using for a while and bring it to the Medicaid agency.

Another piece that is not getting a lot of attention is making sure that consumers available to and MLTSS system are supported. That could be through the enrollment worker, counseling understands the I/DD

system and is aware of the engagement the family members may have in that process that they might not have in other types of MLTSS programs. It is important to make sure that everyone across the board is educated and onboard with the uniqueness of a I/DD system. In Tennessee the Medicaid agency as well as the vocational rehab agency signed in MO you so that both are working consistently around the employment approach to make sure everyone is on the same page and that they are engaging with the providers. This is the boring part of the process. For most people it is really critical for state to be thoughtful in the way they build their procurement. Most states will issue a request for proposal to be contracted for services. It is really important that they make their expectations and priorities clear. If the state has clear goals and recognizes what it is that they want to pursue that makes it easier to convey that to the health plan. You want these data to include program requirements specific to I/DD populations. It is unique and different from other populations. They should really seek demonstrated expertise in a philosophy about I/DD populations that recognize the importance of family members and transitions in employment.

Key pieces ought to be paid attention to. Outside of the regular stuff the plan should be doing they need to be able to the network it's -- and pay claims and provide medical services in most cases. The state has a first opportunity to shape up that program. The issue around minimum standards for financials is universal to the MLTSS program. There are 70 providers that do not have typical life insurance -- there are so many providers that do not have typical life insurance, the state has a very clear role of laying out what the expectation is for the providers. Individuals with I/DD needs to make sure the plan understand those in their not putting up artificial barriers. Adequate rates need to be paid to the health plan and they should really support the goals of the program. You want to make sure that there is enough funding to maintain stability but you also want to build a requirement that will encourage innovation the managed-care contact

the contract is really where the rubber meets the road. You can clearly identify what the plans are expected to do. In this space there are where states could provide specific direction on the staff and what their skill set -- set are. Many to understand person centeredness, building requirements to minimize burden on providers. Attempting to standardize processes as much as possible across the plans. Recognizing the informal support network that individuals with I/DD have and the role that family members have in decision making in formal and settings. In making sure the data very clearly is collected and reported. How the plans capture individual -- individuals in the status competitive employment report that to the state.

Here are a couple of examples. Tennessee developed preferred contracting standards for the ECF choices provider network. They were able to direct the plans and the kind of providers they expected to be in the network. They wanted to focus on integrated competitive employment integration. Their interest in bringing providers that agreed with that vision and approach. Michigan includes a specific employment works policy and its contracts so the plans in the states are aligned in a vision to bring in to implement. Kansas also has specific integrated employment at camps at the plans have to achieve and it

requires them to track their success in meeting those goals. Policies and procedures. The devil is in the details. The contract cannot layout every single operational aspect of program augmentation -- implementation. The more information the state can transmit through the operational guide is really critical and being transparent is also critical. Last but not least from the state and the plan, educate and train and educate and train some more. The need cannot be understated that the system is well constructed and ready to go with the program goes life. Here are a couple of examples that we thought were interesting.

Three plans in North Carolina have collaborated to deliver web-based PCP training to their providers using the direct course curriculum. Is a nationally known planning curriculum. They have decided on their own to do that to meet the state requirements. In Tennessee to plans collaborated to train providers that were interested in participating with the ECF choices program. Did not just leave it to the state. The last piece is quality improvement. It is important in particular to establish quality goals and measures, this is a very tough part of the state system. It is critical for example to get consumer input on what is successful program with like. In many cases the healthcare outcomes feel secondary to meeting their goals. Ensuring health and where fair and minimizing any note -- abuse and neglect. Also having all of the NCI data from the effervescent system. The Bromley can identify where there could be improvements. In Tennessee it is not the Medicaid agency but the I/DD agency that has expertise in this program and they will conduct on-site and performance reviews for their ECF choices program.

Here are the takeaways. A states MLTSS program holds great promise for expanding employment opportunities in improving health outcomes for individuals with I/DD. Delivered a thoughtful design, procurement and oversight will increase the likelihood of success of the program. Taking time to do the implementation well and thoughtfully is critical. The states and plans need to work collaboratively to help providers. The state should not wash their hands and let the plan handle that. Mutual engagement in that process. Engage with providers to hear how things are doing. Measuring quality in ways that are meaningful for people will help the program success. I will stop there. Our paper is online. You can find on the website we also have a link to it. We have the 45 page paper that has more example than we talked about today and I encourage you to take a look at it. We have time for questions.

Thank you Laura and Camille. This moves us into the Q&A portion of the webinar. This weapon I and all of the archives of the business acumen webinars can be found at HCBS.org. We have one question that came in. If you have any additional questions please enter them in the Q&A box in the lower right-hand corner of your screen. Earlier in the presentation and I think we summarized it again. At the end Camille are you familiar with some of the HEDIS measures that have demonstrated the quality outcomes over fee-for-service?

Yes. For example in the states that have developed a conference of -- the start over. The HEDIS only makes sense as a quality measurement barometer if both acute and I/DD services are not separated. The newer

programs that have that data do not have a lot of track record yet. Tennessee, Kansas, Iowa, Arizona has a good set of data that shows for example preventative services access to both women's and men's preventative screening, treating individuals access to mental health services all have kicked up. It may not have been kicking up because they do not collect that data in fewer services. It could be a misnomer to say there is an improvement. You can say it is being measured in overtime you can show improvement on those indicators as he help Lansing clued individuals with I/DD -- the help plans -- the health plans include people with I/DD. The jury is out for programs with I/DD because there are not that many .

And other question. I think it relates to the business sustainability of community-based organizations. What you see happening to the smaller organizations during movement to MLTSS? I would out on how can the understanding of the phases information a shared today be used by many base organizations that are trying to sustain their business . But I think like any other provider that is being impacted by MLTSS I think the core elements with business sustainability apply. Understanding what you do, what it costs and being engaged and active in the system. The health plans are going to be the contracting entity, it will not be the state into -- anymore. Went to providers I encourage them to read and be engaged in the design discussion process.read the contract to be very critical about how you can help them meet the goals that they have for the state. It is a big risk if providers have not been used to being credentialed. They are not used to looking at contracts. The plans will want you to sign these contracts. Data reporting has been limited in systems that may be paper-based. I think all of those are challenges so looking at the ways that your organization has the skills to meet and if you don't to recognize that early on and figure out how to get those is important. There are providers that made the side that managed-care is not for them and they will be in the business. I think of the I/DD space because Medicaid is primarily the only pair for the services that it will be hard for providers to walk away. I think the plans do not want to be enemies with providers. They want to try as much as possible to maintain the existing system because it is important for consumers and their family members. But to the extent that the plans are moving in directions that the states want them to , fighting providers that are consistent with that vision is important. Laura probably has some insight.

I was going to say I think so many community based organizations take this opportunity to be really innovative in their thinking and the way they approach partnering with health plans. Some smaller community based organizations really like them and can expand their services and their footprint across the state to the network. Some providers have chosen have merged and collaborate together in order to make sure they all use and tap into their best skill sets. For example maybe a provider is really good at billing and getting paid on time and another provider is really good at collecting quality data and sometimes they decide to join in order to support each other. That way they can be excess axle -- successful in the health and environment. The most important thing for a provider is to figure out who you need to talk to at your managed-care entity and start having conversations with them as soon as there

is a discussion of MLTSS coming to your state. That way you can learn from them what they expect from a provider and you can show them what your strengths are when it comes to providing services.

Have either of you seen , the question is written as what role does value-based reimbursement play in the transition? Have you seen examples of significant changes in the way the providers are being asked to be paid?

Not yet.

I think that is in development and it is something that is being talked about on a national level. I don't think we're there yet.

In general HCBS services at large there has been very little, a handful states are making baby steps in value-based payment primarily because we have to have measures of success against what to benchmark the payments . What is the benchmark of success and want to get there to make a value-based payment. Baby steps, it is one of the last frontiers to evaluate his payment. >> In the last couple minutes are you aware of any states that have a goal of reducing waiting lists? >> Not specifically as part of their MLTSS program goals but I could be wrong. It is a goal of states when it comes to expanding how they provide support services in as they build efficiencies through MLTSS the thought is to be able to provide more services to more people and eliminate any possibility of waiting lists.

I agree completely. The number of individual cross I/DD that are on waiting lists for service is staggering. The real issue of concern at national and state levels. I agree with Laura. The hope is that by stabilizing program costs and building some innovation and efficiency in the system the hope is to bring more individuals on . There is opportunity there to target services to exactly with the family and consumer needs that might allow the state to get some of the waiting list. We have not seen that specifically in any of the states as a stated goal.

Thank you. With that it brings us to time for today's webinar. I want to thank you both again for your time today and the information that you shared. Thank you to all of the attendees and once again the recording of this webinar and the slides in the archives of all in the pass webinars can be found at [HCBS business acumen.org](http://HCBSbusinessacumen.org) . We'll talk to you again in a month have a great afternoon. [Event concluded]