

Operator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. Today's conference is being recorded. If you have objections you may disconnect and I would like to turn the meeting over. You may go ahead.

Shawnda: Good morning/afternoon. My name is Shawnda Schroeder and I am the principal investigator of the Rural Health Research Gateway, also referred to as Gateway. Today, The Rural Health Research Gateway will be hosting a Webinar entitled: Ups and Downs: Trends in Rural Children's Access to Care. For those of you not familiar with the Rural Health Research Gateway, Gateway is a website that provides easy and timely access to research and findings of the FORHP-funded Rural Health Research Centers, 1997-present. Our goal is to help move new research findings of the Rural Health Research Centers to various end users as quickly and efficiently as possible. This site can be used to find: Abstracts of both current and completed research projects, Publications resulting from those projects, and Information about the research centers themselves as well as individual researchers.

Following today's presentation, the webinar will be posted on the Rural Health Research Gateway Website. You can find Gateway at www.ruralhealthresearch.org and you can join Gateway Alerts to receive periodic email updates when new publications become available, including the archive of today's webinar. Also follow us on Twitter or like our page on Facebook to receive daily notifications on rural health research.

We have muted all lines, but I encourage you to use the Q&A chat box at the bottom of your screen to type any questions you may have for Dr. Probst. At the end of today's presentation, the HRSA operator will open up the meeting for questions, and those written in the chat box will be read if and when there are no more calls on the line. If there are remaining questions in the chat box at the end of our meeting today, we will send out the responses with the archived webinar.

Thank you for joining us today and I would now like to introduce our presenter. Dr. Jan Probst is a Professor in the Department of Health Services Policy and Management, Arnold School of Public Health, at the University of South Carolina, and Director of the South Carolina Rural Health Research Center (SCRHRC). The SCRHRC receives its core funding from the Federal Office of Rural Health Policy.

Dr. Probst completed her undergraduate education at Duke University and her education training at Purdue University (MS) and the University of South Carolina (PhD). Dr. Probst has extensive experience in health services research, with an emphasis on rural and vulnerable populations. She has more than 100 papers in the peer reviewed literature. Recognition for her rural health work includes the 2008 "outstanding researcher" award and the 2016 "volunteer of the year" awards from the National Rural Health Association. Thank you for joining us today!

Dr. Probst: Thank you Shawnda and welcome to everyone who has decided to listen in. I will report from South Carolina we are drying out after the recent heavy rains and I think our friends in North Carolina may have had things a bit worse than us. The question I've been asked is how are things down there?

I'm going to introduce my topic for today which is trends in rural children's access to care and I have labeled it ups and downs which is a title that will become more clear when we get to some of the

graphic data I'm going to be presenting. This is what we are going to talk about, kids, and how can you not start with a cute picture of children. That was the grand prize winner of the National Rural Health Association rural picture contest. Here we have an idyllic rural scene while they are presumably picking up dirt and fungus to bring home to mom. I'm concerned about kids and that is what we are going to talk about today. What I am reporting on are the findings of a study we completed for the federal office of rural health policy that looks at basically a decade's worth of information about rural children from surveys conducted in 2003, 2007 and 2011 and 2012 period. The message I'm going to talk about is there have been some gains in coverage among children although children are generally fairly well covered by health insurance but not matched in service use. Perhaps we will have an opportunity to discuss what I mean by not matched in service use and that are some persistence variance for children.

But first, because I'm a professor I have to talk about what you mean when you say rural? In case we have people new to the health on this call, I tend to think from the Anderson's model of healthcare and health that your outcomes in health are dependent on behaviors which are a function of individual characteristics of the person and the context in which a person lives so all these things like health and satisfaction and what you do and where you get care is in part affected by, rural is a context in the context in which children live. They live surrounded by the availability of the demographics of their population. If the rural population is similar to the urban population with regard to resources, they live where the number of providers are available that types of providers available may be different from other children. There is nothing genetically different that separates rural children from urban but rural is the context that may affect how children and their parents access services.

Backing up in case we have people new to this call, you told us you were going to talk about rural as a context, what do we mean by rural? There are tons of different measures of rural and federal and state policy purposes, but we're going to talk about two, very common geographic measures and I will tell you which when we are using and why. The two common measures of rural are county and census tract. The county level definitions vary a little bit but the shortest version is your county is rural or nonmetropolitan, if you have no urbanized area that contains 50,000 folks or more. County is a good unit. The advantage about counties is they are units of government unlike ZIP codes are census tracts, they don't change when people move in. The disadvantage of counties is it over-bounds rural by which we mean if you look at the county level only, you include too many children in urban and too few in rural because they have some huge counties.

To illustrate that, I'm showing a map now that I downloaded from the U.S. Department of Agriculture that indicates which counties are rural and which counties are urban. Pretty much all of Southern California, most of Arizona and the Grand Canyon is technically in an urban County. Because the counties are big and there is a town somewhere with 50,000 people, if you use a County level definition you pretty much lose California.

One way of defining rural versus urban is county, the second is census tract or also zip code approximation. These were developed at the University of Washington working with the U.S. Department of Agriculture and is a coding structure that depends upon both the population and where people are going to work in the advantage of which urban areas is not you can just subdivide them but that they are smaller categories. This one unlike the one I showed you does work well in the West. The disadvantage of zip codes if we have any undergraduate students out there is they can change over time unlike a County which is pretty much not going to change.

Looking to the next chart you can see what I mean by advantages. California which used to disappear now only has little bits of spots that are urban. The dark blue color is urban. The second darkest color is highly rural and now you can see the United States is neatly divided into urban, rural and highly rural. The whole country is fairly well represented. All of our states have a little bit of each of those areas. This is a nice metric although it is difficult to get to. This is the measure that was used by the national Center for Health Statistics and the Maternal and Child Health Bureau when they produced reports on rural children's health you might have seen previously. We have established rural is a context in which children live. We said there are different ways you can measure rural and we look at how this particular report, the information I'm going to show you was divided up. So if you are in Florida you can see the coastal areas are pretty much urban and when I talk about rural kids, mostly the inland areas of Florida. Everybody should know where they are and I invite you to squint at your state.

One of the biggest sources of information we have that is not clean space but looks at children's health is something called the National Survey of Children's Health which is sponsored by the Maternal and Child Health Bureau. While there are other national surveys that don't include children or they only get small numbers of children, but the national survey of children's health is huge. They are big surveys because they are large enough to have accurate state level data for every state which means you're going to have about 1500 people in every state and by the time you get down to it, there is more than 90,000 observations each time they do it. This is a very large endeavor and obviously very expensive and that is why they only do it for a couple of years. It is a telephone survey. They used landlines in 2003 and 2007 and land lines and cell phones in 2011. If you are in your childbearing age right now or have children, a lot of young people do not have land lines unless they have a specific reason to have one. One needs to sample both populations. This survey helps separate who is they rural child versus not. If you're interested in getting the details, the bullets at the bottom shows where you can get everything you need to know about that survey.

Since the survey has been done there have been previous reports using it. We used it in 2003 to report on rural children's oral health and weight status.

Maternal and child health if you wanted to get additional historic data also produced reports using 2007 and the 2011-2012 survey. There is a lot of information out there. What do and that is different? We are putting them all together. As far as I know our reports are the first to use all three of the status sets to see what is going on. Trends are important. If you jump out of the window off the top of the Empire State building, you are fine for a while but your trend is not going in a desirable direction. One has to look at the history to see what is going on and is accessible or not. Are we getting better or worse? One limitation of what we are doing is given the delays in government collecting and cleaning the data and making it available to researchers across the country, everything we are going to talk about precedes implementation of the Affordable Care Act. I think that would be more of a drawback for adults than for children. A lot of the provisions that influence children under the age of 18 were pretty well covered by health insurance.

The background that will not surprise you, we're going to talk about the context of rural children and who they are and what they have and move on to their health. Like the rest of America although quite not the same rapid pace, rural America is becoming increasingly racially and ethnically diverse.

This means, slight declines. If you look across this transplant African American children represent the rural population of children and a little bit more in large rural counties and small rural counties and this percentage has gone down a little bit over the intervals we are looking at.

What everyone is probably more aware of is American children are a lower percentage because Hispanic children have grown in terms of their representation within persons who live in rural communities. Obviously there've always been Hispanic children in America. We had states Hispanic before they were taken over and part of the U.S. but there is been an increase in the population to where you can see in large rural counties, Hispanic children are now over 15% of all kids and in small rural counties, about 12 and a half. Should you want the details they are all available in our final report.

Slight increases for other children. Basically the percentages of all the children that is white has gone down. One needs to be aware of this largely because of the demographic and socioeconomic status of children who live within minority families.

The second part of the context for rural children, a second part is poverty. I know since this is a largely rural audience that I am preaching to the choir, but I will turn our song books so we know what is going on. We know children are disadvantaged. What this data shows is that they are trending upward, slightly but persistently. This is the percentage of children living in poor families. Urban increased, it was pretty level between 2003 and 2007 and increased a tick in 2011-2012, probably the lingering effects of the recession that hit us in 2008. If you look at the rural lines or the large rural counties that is going straight up and the line for small rural counties a slight upward trend. That means they are not statistically significant and if I say it is going up that means it is.

If you add in the near poor category to the category of poor, you can see the same pattern. Things were sort of flat between 2003 and 2007 and then they get a hair worse between 2011 and 2012. The overall pattern of the same and getting worse is pretty much the same for both sets of kids but notice where the line is for rural children. In small rural counties and large rural counties, the top bar which is the summary at children at 100% and 200%, 200% of poverty is not super rich. More than 45% back in 2003 and roughly 50% of rural kids in 2011-2012 are living in fairly low income families. These are not the ones that are going to be squandering too much on their ballet lessons.

One of the things that is concomitant of poverty is the role of nutrition programs. You can see again the pattern is similar for poor and near poor. This is the proportion of parents that reported their child was receiving free or reduced lunch. You see on the bottom line there is the gray for urban and it is persistently going up. That was going up a little bit even between 2003 and 2007. The line for large rural and small rural both of which are steadily increasing over the period. This is parents reporting that their kid receives free or reduced lunch. These are not official government forms. There is a possibility that perhaps people used to be embarrassed to report their child was receiving a discount lunch and now they aren't. On the other hand, it could be this is the lowest possible expression of this problem because people don't want to report their child is getting a free or reduced lunch. In rural areas, the quality of nutritional programs at the schools is going to affect roughly 40% of the kids. If we want to think about obesity prevention and encouragement of exercise, these are things that are particularly important for rural children. Food stamps, another nutritional supplement are also more likely among rural than urban children. The urban bar is the gray on the bottom in the rural children consistently have higher rates of receipt of food stamps. Rural kids, it is up to 32% versus 24% in urban. We have a problem with childhood poverty in this country and that problem is more acute among rural kids. Again, thinking

about things states can do. For example in our state people that have food stamps can double their food stamp money if they spend that money at a farmers market. A policy intervention to try to increase the availability of fresh, nutritious and low-calorie foods to family and children.

This is interesting, for those of you who might be dealing with special populations. The proportion of children based on their criteria used by the national health statistics is the child has a health problem that is expected to last six months or more and as a result this child requires an exceptional level of care. They have fancy criteria to use to implement that. The portion of children reported to have special health care needs as increased just a bit over the decades. But it has been consistent. In the urban and rural children, the portion having a problem has increased just slightly and the red bars sort of indicates aligned along children. There is not significant change in the small rural counties but the levels of change urban change were living in large rural areas.

Insurance coverage, which is a plus, we have got a number of children depending on nutrition support increasing, but we have also the portion who have reported health insurance going up. You can see each of these categories, it was kind of flat and then went up during the end of the period of observation. If you look at it as a whole between 94% and 95% of all kids have some form of health insurance coverage, which is good. They are not going to be tracked forever because their parents can't afford to take them anywhere. It is good for rural practitioners who get reimbursed for seeing these children.

What is interesting, largely due to a number of states expanding Medicaid eligibility requirements for children, there is a big proportion of children in poverty covered by health insurance and in this slide, rural is doing better. A greater portion of rural kids are covered by health insurance that among urban children which is one of the unusual indicators in that we are doing something right. I'm not sure if it is a function of smaller communities and therefore they are more willing to take on the task of referring children for coverage when a provider encounters an uninsured patient they haven't seen before. For whatever reason we are looking good when it comes to the portion of children in poverty who have health insurance.

Not surprisingly if you put these slides together in your mind, there was more poverty in rural areas and therefore Medicaid is likely to be the principal insurer for children in rural areas. In small rural areas that is currently up to half of all children and nearly half in smaller areas. Since I suspect most people are knowledgeable, I don't have to tell you this means that these are children -- the providers are not getting top dollar for these children as they might for privately insured children but nonetheless they are covered which is something, and we are getting better.

I'm going to call in little bits of data one at a time. African-American children are basically throughout the whole period, although these are significant changes, they are still at a fairly high level and this is just looking at rural children. We are doing pretty well. We are in the upper 90s for the portion of African-American children who have access to health insurance.

Where we are not doing quite as well, I don't know the functions of state of residents or whether it is a function of parental reluctance, we are doing less well with rural Hispanic children. If you remember from our earlier slide, we have around 12% to 15% of our children who are Hispanic. There is a gap between Hispanic children and African-American children and persons that might be listening serving Hispanic kids might want to think about what could be causing it and maybe put in suggestions doing the question and answer period.

Other children, and I apologize if we have it listed Native American or Asian-American because there are so few of those children, the data set itself does not sort them out for all states in a way that would allow us to report individually on those populations so we can all we can do is report on children whose race ethnicity is neither white, African-American or Hispanic. You see there is a picture for minority kids and their health insurance.

White children were pretty much covered all the time. There were slight increases that I couldn't put them in. They would fit with all the other kids.

Before we go any further, we have gone over the rural children's context with poverty and we have noted the population in rural is increasingly diverse and remains more likely to contain poor and low income families and be dependent upon nutrition programs. Nonetheless, and overwhelmingly majority of them have insurance coverage. Are they able to translate this into stuff?

This is the first slide for the ups and downs and if there is a way we can have a discussion at the end, I would love to know what people's opinions are on this. Between 2003 and 2007, in a small geographic locality, the percent of children reported to receive a wealth kid visit, the stuff that is optional on the parents part, we were doing great in terms of the change and improvement between 2003 and 2007 even though there were still disparities. Rural seemed to be getting better. As you can see, everybody went down. I am not entirely sure what was going on. If it was a hangover of the recession because bringing a child to a visit requires a person to take off work and people do not feel they could do that, I'm not sure. But across all categories of children there was a downward trend between 2007 and 2011-2012.

This deepness of the up and down is greater for poor kids than for all kids. The top bar that says all kids is literally all kids. The lower three bars are urban, large rural and small rural living in poverty. They went up faster and they went down faster. Again, I am looking at the data. I can speculate it is an effect of the recession, but I do not definitively know why this is going on.

This looks at the same data and addressing preventive dental visits. We only looked at preventive visits. What proportion of parents said their child had a preventive dental visit in the last year? These are age-appropriate children from the age of one on. There is a modest appearance of the hat affect although the change is a nice upward trend between 2003 and 2007 that does not seem to have dropped off quite as much at these were urban and small rural children in the use of preventive medical services. There is preventive medicine for kids and poverty and for everybody. Here is dental. The other thing I would like to point out, the dental visits are a little bit higher.

Again for poor children there is a lag. The topline again is all children. The bottom lines are poor children sorted by urban kids, large rural kids and small rural kids in improvement between 2003 and 2007 and then a flattening. Whatever we were doing that was right, either we stopped doing it or barriers occurred which impeded on growing progress.

We have seen that rural children are insured -- we are a little bit concerned that aren't hitting there well baby and dentist visits the way they should be. Doesn't matter? What are the health outcomes among children?

There it is. The world's most boring graph. 85% straight across-the-board say my child is in excellent or very good health. It is one line, my kids are healthy, nothing has changed, which is interesting because the preventative visits have gone down so how do they know their child is healthy?

Now let's piece that out a little bit. The topline between 85 and 90 is a line for all kids. There is that boring 85%. Now let's look at what is happening among poor kids in here is another one of our rural success stories. A rural parent, nothing significant is going on here, these modest changes -- more likely to say their child was in excellent or very good health which is nice. In an ideal world and given the fact all these children have access to health insurance or virtually all of them, one would not expect quite this many disparities in the health status of the children. Theoretically they have equal financial access to at least the clinical resources to help them stay healthy but nonetheless they are not perceived to be as healthy.

This is another boring graph in that there is very little significant change. This is the same question except instead of being asked overall what you would say your child's health is excellent, very good, average, fairly poor or poor, this time the same question was asked about children's teeth. Only about 70% and with very little change over time, parents report their children's teeth are in excellent or very good condition which is interesting to me. If there is a bias to report, it should appear all over the board. Somehow parents are much more likely to perceive teeth to be less good and their overall health which may be -- this is just self-report. It may be the pain of getting a cavity filled makes parents more sensitive to what is going on with their children's health and therefore we have an indicator. We do get preventative services for medicine and teeth and private insurers may not cover these were children. If there is a disparity on their parents perceive their children's overall health and how they perceive their oral health.

As one would expect when you intercept poverty with those questions, you get a lot of people who report, a little under 50% per rural and a little under 50% for urban. Only the small portion of parents report their children's teeth are in excellent or very good condition. If we have anyone listening who has been around for a while and remembers Dr. Marcia Brant used to be the Federal Officer for Rural Health Policy Administrator, you will remember how vehement she was that the mouth is part of the body in you should be willing to be recommending to pull out a tooth than cutting off a toe if it becomes infected, but nonetheless we have a lot of people whose children's teeth are not good as perceived by the parent which is why we probably need more programs than we have at present that focus on instructing at-risk moms and young moms on the best way to take care of their child teeth.

This is been a total data fling at you. I have thrown out great bunches of data and so this is sort of my wrap-up slide and after this I hope people have questions because I have questions and I think people in the audiences may have answers and insight that I lack. It looks to me as though we're making progress we are making progress in some areas. Rural children are increasingly covered with health insurance so at least nominally they should be up to get into see her provider. Nonetheless, rural disparities persist across the measures of access. I am concerned about the group appearance who do not see their child oral health as excellent or very good. As most listeners are probably aware, there is increasing evidence that suggests the condition and diseases that arise in the mouth have affect later on cardiac health and maternal health and across a range of indicators that teeth are not disposable. We are facing increasingly bad conditions for rural kids. Poverty levels continue to increase among rural children in a way they have not increased among urban children. Urban rural disparities and the resources available

to children continue to be present. That coupled with the declines in preventative visits which I hope when they do the next iteration of this survey we will say it is back up -- we will see it as backup. -- developmental instruction from their parents this could translate to worse outcomes in the future as these children age and take whatever problems they might have accumulated in childhood. Those are my children, they are a little bigger than that now, looking impressively rural. I will direct you to our website which has further information about our past studies and I would like to give a shout out to the people who make this all possible, our funder. And the last shout out to the Rural Health Research Gateway who is sponsoring this call, and will have all of our stuff as well. Realizing I had finished a little early, I have left us 15 minutes to get input from people watching these numbers and might have insight and discussion to offer.

Shawnda: Thank you, Jan. I do want to turn it over to any questions that might be on the line.

Operator: If you would like to ask a question press star than one and unmute your phone and record your name clearly.

Again, if you have any questions on the phone please press star then one and record your name.

Dr. Probst: This is Jan, questions or observations. If you want to tell me why you think something is happening, I would love it.

Operator: No questions on the phone.

Shawnda: There are no questions in the Q&A box either. I guess you did a thorough job of discussing this for us. That there are no questions.

Dr. Probst: If questions occur to you later, please contact me. For some but not all states, I can give state specific information but if you go to the website in the beginning, the Maternal and Child Health Bureau does have a website where you can search a lot of these indicators at the state level. You can look at some of the values for your state if you want to double check and get more information you can use for your own project planning.

Shawnda: I do want to say there have been requests wondering about whether or not they can receive a copy of the slide presentation and I went to remind all of you we will be putting all these slides and an archive of today's webinar on the Gateway website and send that out through our e-mail alert. If you are not subscribed, please go ahead.

We now have a couple of comments. If I do not share it correctly, those of you submitting them feel free to call into the operator to speak. One of the observations is, The trend lines between the lines of children were consistent so whatever effect of the lines affected them regardless of poverty levels. Two main it seems like the economy as it takes years for a family to recover.

Dr. Probst: Good point. I'm writing these down.

Shawnda: Jan, I can send them to you when we are off the phone call today.

One question is, What data do you think is missing from the surveys used?

Dr. Probst: That's an interesting question. Could the person clarify? Do you mean people did not report or are there questions they didn't ask that they should have asked?

Shawnda: I wouldn't mind hearing your opinion on both. We do have a clarification. Were the questions that should have been asked?

Dr. Probst: Yes, I have an opinion on that. This questionnaire is enormously thorough for people interested in how people raise children. Whether they have family meals together or whether the child was breast-fed. One thing that was present in the 2003 survey and was dropped from subsequent surveys was a series of questions asking about how families deal with this agreement and the options ranged from discussing things calmly and shouting and up to throwing and hitting. That was interesting because I think that is a proxy measure for domestic violence that it would have loved for the Maternal and Child Health Bureau to continue with. I'm not sure why they dropped it. The other areas with hindsight being perfect we probably would have liked them to figure out if they could discreetly address if the child is exposed not just to smoking but if the child is exposed to someone who misuses prescription drugs. Given the opiate crisis in rural America, again, you don't know how well people would have responded but I would have been curious to see. There are two sensitive issues. The domestic violence series of questions after the 2003 survey and anything that might get at children living in danger because the parents are engaged in inappropriate behaviors beyond smoking.

Shawnda: Another individual shared they have a significant issue with healthcare provider shortages in rural areas and in addition they have healthcare facilities that have closed. They are saying this may be the reason there is a decline in preventative visits and not access to that care.

Dr. Probst: Great point. That is something we can check out is we are working on future analyses. Like I say, I'm always willing to hear. Cool. What else we got?

Shawnda: Are there plans for research in the area of rule children with disabilities?

Dr. Probst: I'm going to ask a further question. Maybe? Through this survey we can identify children with special health care needs. This ability goes beyond that and I speak as a parent of a blind son, I have not investigated to see how many of the children in this survey have healthcare problems that would disable them from the point of mobility or even learning. Very interesting question there is in addition the National Center for Health Statistics and the Maternal and Child Health Bureau also do a survey of children with special health care needs but a test of focus on chronic disease more than disability. If you could send a note in clarifying what you mean, let's see what we can think about.

Shawnda: Do have information on age of providers of the number of primary care physicians as primary care providers age and retire, are there others taking their place or will this essentially be made to be a percentage of individuals and preventative visits decline?

Dr. Probst: That's a really great question. One of the things we like to use is counties when we do these analyses and good data for how many primary care providers are in a town. There is not for a zip code like a unit so it's not quite the same. If we had to make a trade-off in analyzing places like southern California where using zip codes and have no idea how close any of these zip codes are to the nearest primary care physician or how many of them there are but having heard this from two people it occurs to me we should do a sub study – is our funder listening? It would be interesting to do a sub study were you link it to County availability of providers. Unfortunately due to the national Center for Health Statistics Security rules we can only link and get county level data if we pay a fee and go there and pay an additional fee to do our analysis because that is a good point. We will look into what we can do about it. Other questions? This is great. I'm having great fun with all these new ideas.

Shawnda: I do read only one question but I'm not exactly sure what they are referring to. There is an acronym WCC being used, the question regarding the opinion of health without participating in WCC-- I think they may mean WIC -- whoever sent in this question if you would like to clarify please do the basically what I'm understanding is this idea we might receive ourselves as healthy -- there might be a disparity in identifying -- as a requirement for help.

Dr. Probst: The parent may see the kid is healthy therefore not take them for a visit and even flipping that if a child does have a problem, the parent doesn't recognize because they haven't gone to preventative visits, there is a cycle going on there.

Shawnda: And there was clarification, Well Child Care. So Well Child Visits

Dr. Probst: If they don't go, they won't find out. You think would be fairly obvious, but it might not be, as a new mother it was not obvious to me my child had asthma until the child's dentist pointed it out which is very interesting. This is about the age of 18 months.

Shawnda: Do you have information from the research you have done with regard to pediatrics with regard to behavioral health?

Dr. Probst: We have not examined that recently, but that is something we should perhaps look into.

Shawnda: At this time we don't have any other questions on the line or in the Q&A box. I do want to thank Jan and thanks to all of you who joined us on the call today. Again we will have this information available to you through our website and through Jan's website through the research center. Thank you for joining us it would've forward to sharing the PowerPoint and the archived webinar it would encourage you to share those resources with any colleagues you think this would be beneficial for. Thank you again, Dr. Probst for sharing.

Dr. Probst: Thank you for having me and thank you to the people who contributed ideas.

Shawnda: Have a good afternoon everyone.

Operator: That concludes today's conference. You may disconnect at this time.