Transcript:

The Overdose Disparities Series Part 5: MN Strategies for Expanding Naloxone Access and the Role for Fatality Review Teams

Presenter: Cody Bassett & Sam Robertson
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ANN SCHENSKY: Hi, everyone. Welcome. We're just going to give everybody a minute or so to get in and get settled, and then we'll get started. OK. It is the top of the hour, so we will get started. Welcome again, everyone, to strategies for expanding naloxone access and the role of fatality review teams in Minnesota.

Our speakers today are Cody Bassett and Sam Robertson from the Minnesota Department of Health Drug Overdose Prevention Unit. This webinar is brought to you today by the Great Lakes PTTC and SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded through SAMHSA under the following cooperative agreements.

This presentation today was under the cooperative agreement with SAMHSA. The opinions in this webinar are those of the speaker and do not necessarily reflect the official position of DHHS or SAMHSA. The PTTC network believes that words have power and language matters, so we use affirming language to promote the application of evidence-based and culturally-informed practices in all of our activities.

Again, thank you for joining us. We have some housekeeping details. If you are having technical issues, please individually message Kristina Spannbauer or Stephanie Behlman, and they will be happy to assist you. If you have questions for the speakers, please put them in the Q&A section at the bottom of your screen. We will respond to those questions during the presentation. We will be using automated transcriptions for today's webinar. You will be directed to a link at the end of the presentation for a very short survey. We would really appreciate it if you could fill it out. It takes about three minutes. And we are recording this session, and it will be available on the Great Lakes PTTC website in a couple of weeks.

Certificates of attendance will also be issued to all of those who attend the full session. And just as a quick reminder, this is the fifth in our series, and we have added a sixth webinar. It's fentanyl, test strips, grassroots, harm-reduction strategy, and that will be on June 8. We will put the link to that in the chat, and you will also have the opportunity to be directed to it at the end of the webinar.

If you would like to see what else we're up to, feel free to follow us on social media. And again, our speakers today are Cody Bassett and Sam Robertson. Cody is the naloxone coordinator with the injury and violence prevention section at the Minnesota Department of Health. Cody has an MPH in epidemiology from the University of Minnesota Twin Cities.

And before joining the Minnesota Department of Health, Cody was with the Fond du Lac band of Ojibwa, working to learn about and address the opioid crisis in Indian country. Sam is a community drug overdose prevention coordinator with the Minnesota Department of Health's injury and violence protection section. He studies at the University of Minnesota Twin Cities, pursuing a master's in public health.

Prior to joining public service, he coordinated infectious disease and overdose prevention programming, serving Minnesotans at a local non-profit in Minneapolis. Sam's professional and academic interests focus on improving and protecting the health of communities impacted by drug overdose and other health disparities that stem from stigma and discrimination. So welcome both of you, and I'll turn the floor over to you.

CODY BASSET: All right. Good afternoon, everybody. Is the slideshow looking all right? I think so. Awesome. All right. Well, like we said, we're going to be talking to you today about strategies for expanding naloxone access and the role of fatality review teams. So first off, I'm going to start by talking about data and what the landscape looks like here in Minnesota, and then I'm going to talk about naloxone access.

And then, rounding out the rest of the presentation will be Sam. He'll be talking about overdose fatality review and linkage to care across Minnesota, so some very exciting things happening. But first, the drug overdose data. So here, we have our nonfatal drug overdose aggregate data, where you see it's increasing over the years, particularly opioid involved-- like, overall opioid involved.

And we see overdose deaths are increasing, as well, over 2020. In fact, we had a record-breaking year-- the most numbers, 1,008 so far in 2020. And then, this is sort of a geographic breakdown, and I'll talk a little bit about this in a minute on one of the maps I have. So state-wide, again, we see this overall drug overdose death increase, but you see this sort of larger breakaway, I guess might be a good way to describe it, is the metro is actually increasing in overdose deaths compared to greater Minnesota, which is the rest of the state.

And then we continue to see-- we don't have 2020 data on this yet. However, over the years, we've had a marked racial disparity in overdose deaths. So as you can see, American Indians are seven times more likely to die from drug overdoses compared to whites, and African-Americans are twice as likely to

die. And it's been increasing over the years, but like I said, we haven't seen 2020 yet on this breakdown.

And then this is just, again, displaying how the disparities have grown over the years from 2010 onward. And now I'll talk a little bit about naloxone access in Minnesota. So I'll start us off with a little bit of notable legislation. So in 2016, that was actually when we expanded access to naloxone-- or the state expanded access to naloxone-- by allowing pharmacists to write prescriptions for naloxone via a naloxone protocol.

It just made it easier. So instead of having to go to deprescribe and create a-- it just removed some of those barriers. So now, with the protocol, the pharmacist can on the spot-- if they're filling a prescription for Oxycontin or whatever-- they can on the spot ask, would you like to add naloxone to this? And then they go through the education and training necessary.

And then in 2019, very recently, we had the Opioid Epidemic Response bill pass. So this actually raises funds from manufacturers and distributors, and those funds are then used to fight the opioid crisis. And managed isn't necessarily the correct word for the advisory council that was made as part of that bill, but it's an advisory council, so they advise.

And currently, the status in the state-- I can't remember the exact number because it changes every once in a while, but I know that there are over 300-- I want to guess 340 might actually be the accurate number-- the number of pharmacies that have a naloxone protocol, and it's present in most of the counties in the state. You'll see there's a few here and there that don't have the little dots on them, and those counties are-- some of them are sparsely populated.

In northern Minnesota particularly, people are really spread out. And I should note that this map does not feature those with a company protocol, so like Walgreens or CVS, which would greatly increase the locations on there. But like I said earlier, this protocol just simply allows pharmacists to create prescriptions for naloxone pretty much upon request-- anybody can walk in. It doesn't have to be for a prescription. And then talking about naloxone distribution in the state-- it's very interesting because there's a lot of different groups right now. But overall, the state partners with EMS and harm reduction groups for distribution to best reach first responders and those who are most at risk of an overdose. Excuse me.

Partners provide naloxone, naloxone kits, training, education, and resources-- pretty much everything naloxone related. And there's a variety of funding sources that do support this activity, whether it's via SAMHSA, our state funding through the OERAC bill that I mentioned, and then BJA-- a few others.

So this is one of those maps I mentioned earlier, and you'll see that there's that purple region right there, the metro, and then everything else is considered out of state. So SAMHSA SOR and our state OERAC funds support our EMS partners. And this relationship started with us here at MDH in 2017 and continues to today, and we're hoping it can go quite a bit further for this epidemic.

But like I said earlier, they distribute and provide training and resources to first responders, so we're partnered with the eight EMS regional directors. And this strategy was chosen because they already have the networks established within their respective regions. They know how their regions function, and they all operate a little bit differently.

So tackling this without them would be an unbelievably complicated and monumental task. So we have great partners. And then our harm reduction partners that I work with specifically, they also receive OERAC funding. And I don't want to go into the details, but I don't work directly with them on those funds.

But through funding with the BJA COSSAP, we have partnered with two syringe service programs who work directly with those most at risk of opioid overdose to also distribute naloxone, and they also provide education and training to clients and any group that they distribute to. So the way it works is, we have one group, Southside Harm Reduction, who works primarily in the metro area.

And then Rural AIDS Action Network works primarily in greater Minnesota, and it's just sort of where they specialize. They can go into each other's sort of quote unquote, "territories." It's not a clean break or separation. There's a lot of collaboration that happens in the EMS regions as well as the harm reduction partners.

Like I say at the bottom here, they're part of a network and supply other groups and can back each other up and support one another. And then lastly, just to kind of finish off my part of this-- so we're really excited about this future project. And I generally don't like to discuss these sorts of things until they're more firm, but we're working together with our Department of Human Services in the state to develop a naloxone inventory system, because as I've kind of covered through here what naloxone looks like in the state, there's a lot of partners.

And it's tough to get all of those different data sources or spreadsheets or what have you all lined up together. It's quite a task. So to make things easier on the surveillance and data tracking side, we decided to come up with this singular system that all partners would use.

And it would also make it-- the goal is obviously to make it easier on everybody, so whether it's the first responders or the Sheriff in this one county

who maybe aren't fully aware of naloxone being available to them or a brand new group in the states that doesn't necessarily know about the naloxone network that exists.

They can visit a web portal and place a request for naloxone, and then we on our end can track where the naloxone is going. We're also planning to have it so we can do smart distribution and shuffle around near-expiring doses to high-need areas and then refilling that need in those with maybe lower-demand areas. So it's really exciting, and I'm looking forward to sharing more with folks as it develops and gets implemented sometime soon, hopefully. But just to end my section here, the important question to be asked afterward is, naloxone is great for saving folks from the overdose, but what happens after someone is revived? It's not just a-- I think we all know that it's probably not best practice to save someone and they just move away from that. So I think Sam's going to talk a little bit about what could be some wonderful next steps we're seeing here in Minnesota. Thank you.

SAM ROBERTSON: Thanks so much, Cody. Let's see here. Just going to share my slides really quick. All right. OK. Thanks so much, Cody, for kicking us off, and thank you to everyone at PTTC for having us this afternoon. This is a real treat, so thank you so much. I'm going to ever so quickly spend a moment talking about our exciting new linkage to care teams that are working to facilitate that next step that Cody mentioned after naloxone-- so sort of that postvention idea.

And then I'm going to focus my time on talking about overdose fatality review teams, share a little bit about a pilot that we had in the city of Minneapolis in 2018 and 2019, and share a little bit about the future of overdose fatality review work in Minnesota.

ANN SCHENSKY: I'm sorry to interrupt you. It was in presentation mode, and it is not appearing in presentation mode right now. You want to try to-- that looks great. Perfect.

SAM ROBERTSON: Looks great? OK, perfect. Thank you so much. All right. So like Cody mentioned, we have really strong partnerships with the syringe services programs that provide harm reduction services to folks who use drugs across the state. Through the CDC OD2A grant, we are able to supplement the main funding that SSPs get with some additional supplementary funds to expand their capacity to be able to do linkages to care work.

And so with that in mind, we have partnered with seven syringe services programs across the state. There are a mixture of fixed sites, so inside a building and then mobile, so more outreach focused-- so that way, we are able to have a wide spread of services available to folks. And what they do with this funding is they've expanded their capacity to perform active referrals

and warm hand-offs to substance use disorder treatment, recovery supports, and harm reduction resources.

And one thing that's particularly neat about this work with the SSPs is that, while they all do this work as part of their individual agency that they work for, they also work in collaboration for outreach. So part of the focus of this work is expanding outreach to Minnesotans who are housed with substance use disorders.

And so they have been working in collaboration to host what they call pop-up events at various encampments and other places that serve homeless folks throughout the state of Minnesota. And so for example, in the city of Duluth, the SSPs are all working in collaboration to host a pop-up event tomorrow night that's going to provide HIV, hep C testing, as well as substance use disorder linkage to care-- some wound care-- as well as a resource facilitation as well.

So it's kind of cool to see them work both separately as well as in a team. Next, we have our EMS linkages to care teams. These are funded through our BJA COSSAP grant. So like Cody mentioned, there are eight EMS regions across the state. Some of our EMS regions work independently on this linkage to care project, and some of them are working together as a kind of multi-regional team.

So there's a total of five EMS regional teams that are providing statewide linkage to care coverage. And specifically what they're doing is, their EMS agencies in each region are partnering with local peer recovery specialists to be able to do some post-overdose follow-up linkage to care work with folks who have survived, recently, an overdose.

So they're joining EMS follow-up runs, and so they're actually visiting people at their home with their consent, and they're also being embedded in emergency departments throughout the state of Minnesota-- so that way, when folks are in an emergency department due to a non-fatal overdose, they can be connected with resources right then and there if they're feeling able to do so.

Next, I want to highlight a mighty team of one with our state-wide Department of Corrections re-entry planner. So this position is funded through CDC OD2A, and this position works full time to support incarcerated individuals with substance use disorder with continuation of care after release.

So the Minnesota Department of Corrections is actually the largest substance use disorder treatment provider in the state of Minnesota. And so this person works with incarcerated individuals at all corrections facilities across the state-- so they work as kind of a float position-- working with all of them to get them either continued to care if they were receiving treatment or recovery supports

while incarcerated, or to start any care that they're hoping to receive after their release.

And so right now, this is a mighty team of one, and we're hoping to work with the Department of Corrections to expand this project over the years. All right. Next, we've got the Saint Paul Police Department COAST team, and that stands for Community Outreach and Stabilization Team. This team focuses on working with Minnesota's homeless population as well as with Muslims who experience overdose and mental health emergencies.

This partnership has funded a licensed alcohol and drug counselor to join this team for similar post-overdose follow-up to the EMS regions. Some special work that they do is they actually do-- they have equipped-- oh shoot, sorry. There we go. They have equipped a bus to be able to perform outreach to homeless Minnesotans, and they also have drop-in hours at various shelters throughout the city of Saint Paul.

And so they're, once again, meeting people with substance use disorder where they're at to be able to provide treatment linkage work. All right. I'll pause for a quick moment here and see if there's any questions.

ANN SCHENSKY: We do not currently have any questions. But just as a quick reminder, if you do have questions for either of the speakers, feel free to put them in the Q&A section at the bottom of the screen.

SAM ROBERTSON: Fabulous. Thanks for that, Ann. All right. Well, I will go ahead then and dive into some of our efforts around overdose fatality review teams. All right. So the overarching fatality review team model has been proven effective over many decades in identifying prevention strategies for suicide, maternal mortality, and other preventable deaths.

Every drug overdose death that happens is preventable, and the fatality review model is showing effectiveness in developing innovative and effective overdose prevention strategies across the US. The illustration on this slide represents the coming together of individuals, families, and the systems that serve us to create roots of community connectedness and social cohesion. So what is an overdose fatality review team?

It is split into three parts-- coordination, planning, and implementation. The first step is coordination. Convening experts from public health, public safety, behavioral health, and community for the actual fatality review meetings. Then, as a group, they assemble and review the timeline of one dissident's life who has died by drug overdose.

Then, they work together to identify and recommend realistic changes to the systems that serve people living with substance use disorder. Finally, last but not least comes the implementation of the recommendations and changes in

systems and policies that are identified through the fatality review process. This is all done to promote healing and prevent future drug overdose deaths. So I'm going to start by sharing a little bit about a pilot overdose fatality review team that the Minnesota Department of Health partnered with the city of Minneapolis health and police departments. We also received technical assistance and evaluation support from the Bureau of Justice Assistance. So these core partners co-planned and attended each fatality with [INAUDIBLE], of which we had six over the course of one year.

Through these partnerships, some highlights that we noticed-- actually, first, sharing some partners that were at the table, we were able to convene county medical examiners, Department of Corrections treatment providers, first responders, 911 dispatch, and much more. And gathering all of these entities at the table was a real highlight for us.

This really helped us establish new and strengthened partnerships through participation from a wide range of agencies. One lesson that we did learn about convening these partnerships, however, is that it's really important to provide potential partners with a concise and easy-to-understand overview of the purpose of overdose fatality review teams, and then also providing from the up front concrete and easy-to-understand data governance and confidentiality information.

Regarding the process of overdose fatality review teams, we learned that one thing that is really key for success is each member's mutual agreement for a space of no judgment or blame. We're all gathering together to prevent future overdose deaths, not to place blame for past overdose deaths. Also, one thing that's really important is making sure that there's honor for the decedent that's being analyzed as part of the fatality review process.

We also really found it valuable to have a third party facilitator, and also a third party evaluation team. This was really, really valuable for us in terms of getting some feedback that had no bias from any participants. Through the process, we did learn that it was really important to use uniform data collection and decedent timeline tracking documents to improve accuracy of notes collected at the time of the meetings.

So these are all examples of recommendations identified from the Minneapolis overdose fatality review pilot partnership that are actively being addressed by the appropriate agencies. Recommendations that come out of the OFR process can be small, easy-to-change process improvements to implement right away by all of our team members, all the way to policy recommendations to provide all lawmakers and stakeholders in your region. So with BJA COSSAP and CDC OD2A funds, we are thrilled to continue our overdose fatality reviewing venture in Minnesota. The five EMS regional teams that are working on treatment and linkage to care are also implementing fatality review teams in their region. Furthermore, we are working with three culturally specific agencies to do a specific deep dive into

overdose deaths that have happened in indigenous communities, African-American communities, and East-African communities in Minnesota.

And so we're really excited-- we're in the middle of our training period right now with first fatality review meetings happening across the state this July. And so to conclude, just a quick take-home message about all of our teams is that they really do strengthen the systems of care that serve people suffering from substance use disorder. They heal communities and they prevent future drug overdose deaths.

And those are our slides, so we're happy to take questions.

ANN SCHENSKY: Great. We have a couple of questions. Will anyone be able to request a naloxone kit through the new web portal? Will there be a limit to the number of kits a person or organization can request?

CODY BASSET: That's a good question. Let me see. We're still sort of having these discussions, too. And I love the idea of anybody being able to go on and request it, but I don't know if that's going to be an option immediately. But I think we're going to sort of restrict it-- to get into the logistics of it, we're probably going to keep the existing partnerships we have.

And there will be like some smart variables on the back-end when organizations or groups put in their request so they'll be routed to the appropriate partner-- whether it's a regional EMS director or one of our syringe service program partners. And they'll have final approval over something like that, I think is the way we're going. Yeah.

Like, if somebody puts in a request for 30 kits then, if that is out of the norm or something that that partner then wants to follow up on, they can definitely do that before they fulfill that request. I think that answers the question.

ANN SCHENSKY: Great, thank you. Our next question is, I'm interested in understanding the involvement of the Saint Paul police and doing outreach. With the controversies nationwide, but especially in the Twin Cities, about reducing the overreach of police, I'm curious to understand why police were chosen to do outreach.

SAM ROBERTSON: What a fabulous question. So I think that that really is unique. I think this partnership was created uniquely, just due to the specific work that this COAST team does-- the community outreach and community stabilization team. So they specifically do outreach as plainclothes officers, and their model is to work in partnership with LADC-- or Licensed Alcohol and Drug Counselors-- as well as licensed social workers for mental health.

And so I think that they-- I'm trying to think of how I want to put this. They are really, really person-centered and really trauma-informed, and so I think that this partnership is really about changing the way law enforcement works with

people who experience overdose and mental health crises to have the response be out of specifically the law enforcement officer's hands, but more so into a social worker or LADCs expertise. Did that make sense?

ANN SCHENSKY: Yeah. If you asked that question, if you have a follow-up to it, please feel free to put it in the Q&A and we'll jump back to it. Someone else asked, what specifics does the team review-- I assume the fatality response team?

SAM ROBERTSON: Oh, that's a great question. So there are all sorts of specifics that can be reviewed in an overdose fatality review your team. So for example, the folks that we try to invite to the table are really wide-reaching, from criminal justice to CPS, EMS, health care providers, medical examiners. So just for example, for a medical examiner, the data that they want to be collecting is-- let's see here. I'm just pulling up some examples. OK. So for example, the medical examiner is going to bring toxicology results to the table, and then health care providers-- for example, if the treatment provider that has worked with the decedent joins to bring any kind of information about their time in a treatment facility.

They also talk about intersecting health issues that may have to do with-- that may be intersecting with overdose-- such as infectious disease-- and then also be any sort of CPS involvement that they or their children may have had come to the table to be able to learn more about ACEs and things like that. And those are just a few examples of the many, many things that can be brought to the table to inform a fatality review.

ANN SCHENSKY: Great, thank you. Someone asked that they would like more information on naltrexone.

KRISTINA SPANNBAUER: And I'll just quickly interject that I actually have the SAMHSA link with info, so I'll put that in there. But Sam and Cody, if you have other information on naltrexone that you want to provide, you can certainly do that. It was kind of a vague question, so—

[INTERPOSING VOICES]

CODY BASSET: I mean, if it's naltrexone, unfortunately, that's not really something I can speak to. But I'm naloxone, but unfortunately not naltrexone.
KRISTINA SPANNBAUER: No worries. I have the link to the SAMHSA info on there. So thank you for that question. Go ahead and follow that link for more information.

ANN SCHENSKY: Thank you, Kristina. We have our first OFR team in Lexington, South Carolina. We are challenged to have more local nonprofits, such as recovery communities to participate. Some of this is because data sharing challenges-- law enforcement is concerned about this. What additional nonprofits or relevant groups do you have participate?

SAM ROBERTSON: Fabulous question. I'm happy to take that one. So first, I want to acknowledge that we have experienced some of the same things in the state of Minnesota. And what we've learned-- this is related to your question, I just want to throw it out there. And what we've learned is the point that I made about providing really clear and easy-to-understand information about data privacy to your partners is really, really key to participation.

And so we've learned that working to put together an MDH legal FAQ, is going to be-- we're putting it together as we speak because it's something we've learned is very much so desired by our local partners-- potential other partners. With that in mind, the types of partners that come to the table are really diverse, depending on which local partners.

But in general, what we do is we encourage people to bring together folks from social services, public health, medical examiner or coroner, any health care and treatment providers, EMS that have interacted with a decedent, educators that have interacted with a decedent, any other criminal justice, CPS, and then lastly behavioral health.

ANN SCHENSKY: Great, thank you. That's really good information. Then, the last question is, why not use peer recovery specialists in Saint Paul or a person with lived experience?

SAM ROBERTSON: That's a great question that I don't have a good answer for, besides just thank you for bringing up that really important point and feedback. Thank you so much for sharing. I think that that's a really good idea.

ANN SCHENSKY: Couple more questions coming in. Are there any HIPAA issues for the fatality review teams to examine information?

SAM ROBERTSON: Oh, there sure are. Absolutely. So this has been one of the biggest-- not barriers-- but challenges that we're currently overcoming is getting around all the data privacy-- not getting around, but making sure that we fully understand all the data privacy issues. One thing that I will say is that data privacy is going to really depend on what state you live in.

For example, there are some states that actually have legislated statutes that mandate overdose fatality review, in which case it is really easy to put together fatality review teams. So it's easy in a state like that. Unfortunately, Minnesota does not have such a statute. However, we do have statutes that allow for community-based organizations and other health care-related agencies to gather for the purposes of epidemiological investigation and improving the health of Minnesota.

And so with that in mind, through that statute, overdose fatality review teams are allowable in the state of Minnesota. But I just want to put it out there

again-- I know I just said it, but-- that it definitely depends state by state, so you want to make sure that you do a little digging, depending on where you live.

ANN SCHENSKY: Great. Let me see. Pam, who asked the original question about getting people involved, said, we initially had two RCOs-- peer support-- to be on our OFR, but law enforcement is concerned about data privacy and what they would have to redact if there were partners that were not part of state agencies. So I think, Randy, that might address a little bit about your peer recovery specialist question as well.

We do not currently have any more-- oh, no, I spoke too soon. Do you have examples of your protocols and guidance for operating the fatality review teams that you can share?

SAM ROBERTSON: Oh, what a fabulous question. I would be more than happy to share Minnesota's overdose fatality review implementation guide. I can throw that into the chat in just a moment. This implementation guide that I'm going to share covers all aspects of overdose fatality review team planning and implementation.

And I also just want to give a shoutout to the Institute for Intergovernmental Research. Their guide inspired our guide, and so I just want to make sure that I give them credit where credit is due. I will go ahead and throw that file in the chat for everyone.

ANN SCHENSKY: Great. Thank you. And we can also add that to the website when we post the recording, so that—

[INTERPOSING VOICES]

ANN SCHENSKY: I'm sorry. If you're not able to put it in the chat, Sam, you can just email it to us, and we'll make sure we get it out to everybody. Does anyone have any additional questions? All right. Just a quick reminder that there is a sixth webinar in this series, and you'll get that information at the end of the webinar, and it is also in the chat.

And we will forward to any of the information from Sam about the protocols. So I just want to thank everyone for their time. Thank you very much, Cody and Sam. We appreciate your sharing your knowledge with us. These sound like great programs. So if anyone else has any additional questions-- or doesn't have any additional questions-- we'll wrap it up for the afternoon.

CODY BASSET: This is Cody. I actually wanted to pull a quick Minnesota goodbye.

[LAUGHTER]

ANN SCHENSKY: By all means.

CODY BASSET: Yeah. So I just wanted to comment earlier-- and I'm sorry if this was covered in earlier question-- but there was that question about concerns about redacting information-- regarding OFRs-- about what information could or should be shared in the room. That implementation guide-- we'll talk a little bit-- if talks about that. I think there are examples in there, correct, Sam?

There are examples of agreements any participants can have on-hand that keeps everything from the OFR discussion in the room. Unless I'm totally misremembering things, Sam.

SAM ROBERTSON: No, you're absolutely right. Yeah everyone, this guide covers every facet of overdose utility review team planning you could possibly think of-- from data privacy to respecting the decedent, so it's got all sorts of good stuff in it.

ANN SCHENSKY: That's wonderful. What a great resource. Thank you for sharing that with us. So again, thank you, everyone, for your time, and we appreciate you spending your afternoon with us, and Sam and Cody for providing us with all sorts of great information. So have a great afternoon, everyone.

SAM ROBERTSON: Thank you so much for having us. Take care, everyone.

CODY BASSET: Thanks.