Jennifer Hannah: Good afternoon and thank you for joining us today. I am Jennifer Hannah, Deputy Director for the National Health Care Preparedness Program or NHPP branch. Before I hand it over to our first presenter, I would like to provide a brief overview of what we will cover today next slide please. Next slide please.

First, we will provide a few quick ASPR Health Care Readiness Programs updates. Next, we will hear an overview of the National Special Pathogen System, or NSPS, from Dr. Richard Hunt, and then an overview of the NSPS Strategy of Care from Dr. Vikram Mukherjee. Afterwards, Andy Van Pelt and a team from General Electric will share details regarding the launch of the new Oregon Hospital Capacity Systems Tool. Finally, we will leave some time at the end for questions from the audience. Next slide.

I'd like to begin today's webinar sharing some exciting news regarding the recent addition of a fourth RDHRS demonstration site: The Southern Regional Disaster Response System, or SRDRS, which is led by Emory University. ASPR recently awarded Emory University a three-million-dollar cooperative agreement to demonstrate how a Regional Disaster Health Response System can improve medical surge and clinical specialty during a national emergency and save more lives. In addition, ASPR also awarded one point five million dollars in continued funding to each of the three current RDHRS demonstration sites to build on their accomplishments to date. All four awards focus on integrating clinical and health care systems’ operational expertise into existing preparedness and response structures at the local, state, and regional level. This involves: Expanding capabilities and capacity for improving disaster readiness across the health care system, increasing medical surge capacity, and providing specialty care – including trauma, burn, and infectious disease, among others – during large-scale disasters or public health emergencies. As the three current demonstration sites continue to scale up their regional disaster preparedness and response capabilities – and as the fourth demonstration provides another opportunity to pilot the concept in a new region – their progress will show the potential effectiveness and viability of an RDHRS. And I believe, a member of our team has already dropped a link in the chat to share the official press release. Next slide please.

For those of you who attended our All-Recipient Webinar on August 11th, we’re excited to share we have recently posted a Story from the Field highlighting the Missouri Hospital Association’s reflection report effort, presented during the August webinar. The story highlights how the MHA derived key insights from hospital data they collected which was then used to identify insights published in two “reflection reports.” These reports later informed biweekly webinars to discuss lessons learned among Missouri hospitals. The full story is posted on PHE.gov. And for your reference, a member of the team will share the story link in the chat. Next slide please.

Finally, I am happy to announce that the Workforce Capacity and Capability Page is now published on PHE.gov. The page highlights the various Health Care Readiness Portfolio information sharing-programs which continue to support health care practitioners nationwide. These programs include the Project Echo Clinical Rounds, Health Care Coalition Response Leadership Course (HCRL), and the Medical Response to Overwhelming No Notice Mass Trauma Course. You can access the Workforce Capacity and Capability Page on PHE.gov or
using the link that our team will drop in the chat. I will now pass it over to Dr. Hunt to provide an overview of the National Special Pathogen System.

Richard Hunt: Thank you Jennifer. My name is Dr. Richard Hunt, and I am a Senior Medical Advisor with ASPR’s National Health Care Preparedness Programs Branch. Before Dr. Mukherjee provides an update on the National Special Pathogen System, or NSPS, Strategy of Care, we wanted to provide a brief review of the NSPS. This slide provides a snapshot in time reflecting how ASPR set up the NSPS using emergency supplemental funding for the COVID-19 response. In order to respond to the immediate crisis, ASPR officially announced the launch of the NSPS and administered a total of $350 million in emergency supplemental funding to support its four components listed on this slide, which included: 10 Regional Ebola and Other Special Pathogen Treatment Centers, or RESPTCs; 62 HPP recipients and their 55 Special Pathogen Treatment Center sub-recipients; 53 Hospital Associations; and The National Emerging Special Pathogens Training and Education Center, or NETEC.

As ASPR moves forward and we look at ASPR’s Health Care Readiness Programs Portfolio – for both special pathogen preparedness and all-hazards readiness – these components may shift over time or take on new roles. Additionally, as NETEC continues to refine and implement the strategy for a National Special Pathogen System of Care, these components may look different than they did at the time of the original emergency response. Through NSPS, ASPR supports the urgent preparedness and response activities and needs of hospitals, health systems, and health care workers on the front lines of the COVID-19 pandemic. In the long term, NSPS aims to create a nationwide systems-based network approach for all special pathogens, similar to other hub-and-spoke models that improve patient outcomes, such as the trauma, cardiac, and stroke systems of care. Next Slide.

The NSPS was established in response to the COVID-19 pandemic. With support from annual appropriations and COVID-19 supplemental funding, ASPR evolved the former Regional Ebola Treatment Network into the NSPS. Key changes from the transition included: renaming institutions for an increased and more explicit focus on all special pathogens, such as rebranding NETEC, which was formerly known as the National Ebola Training and Education Center, to the National Emerging Special Pathogens Training and Education Center; and adding hospital associations as a recipient group to more rapidly distribute funds to health care entities without placing additional burden on public health.

The NSPS also expanded the system’s focus from Ebola to any special pathogen and matured the regional approach into a formalized national system and strategy for special pathogens, similar to other national systems designed to address specific types of clinical care, such as the national trauma system. As the national strategy continues to evolve, the NSPS aims to strengthen health care response capabilities at the local, regional, and national level. With that I’d like to turn this over to one of the co-PIs for principal investigators for NETEC from Bellevue hospital, intensive care physician, who has been a remarkably stellar advocate for special pilot and care Dr. Vikram Mukherjee.

Vikram Mukherjee/NETEC: Thank you, Dr. Hunt and thank you everyone for inviting us to this presentation. Next slide please, Megan. For the next few minutes, we’ll just talk about the
National Special Pathogen System of Care. Joining me in making this NSPS System of Care are Dr. Mehta and Dr. Lowe. Dr. Mehta is infectious disease from Emory University and is on service and could not make it. I’ll request Dr. Lowe to kindly introduce himself before we get started.

John Lowe: Thanks, Vikram. Greetings everyone, my name is John Lowe. I'm a faculty in the School of Public Health at the University of Nebraska Medical Center and one of the co-primary investigators, for the National Special Pathogens Training and Education Center. Again, it's our privilege to talk with the hospital association HPP awardees today and get feedback and input and inquiry on the strategy that we're promoting and pushing forward.

Vikram Mukherjee/NETEC: Thank you, John. Next slide please. As you heard from John, me, Anish, and John are the PPIs for NETEC, the National Emerging Special Pathogen Training Education Center, which has a pretty simple mission statement - to increase the capability of the US public health and health care systems to safely and effectively manage individuals with suspected and confirm special pathogens. Next slide please.

As you heard from Dr. Hunt, we moved from Ebola treatment and education to emerging special pathogen training and education center in 2019; knowing well that the next threat would not be Ebola centric and, as we know, we are a more of an all-hazard special pathogen center. Next slide please.

A year or so ago NETEC was tasked by ASPR to develop a strategy and implementation plan recognizing well that the existing system is fragmented, uncoordinated, and often inaccessible. As you know, right now, this tragedy that's been hitting us over the last year and a half, with more than 715,000 deaths and millions infected, shows credits to the fact that we have a huge unmet need in being able to handle special pathogens better in this country. Over the last year, NETEC has consulted with over 70 stakeholders across the country and with support from Deloitte, our consulting partners, to develop a framework for the NSPS. We've made it a priority to make sure this is a multi-disciplinary, multi-faceted patient-centered approach involving all sectors of health care delivery. Next slide.

We started off this project looking at the gap analysis involving interviewing multiple stakeholders from across the realm of health care delivery to identify gaps that need to be met. As you can see from this slide and the next, we were able to identify multiple gaps and multiple vulnerabilities in almost every facet of health care. Be it care delivery, communication coordination, be it workforce research and knowledge generation, data and technology, monitoring, and evaluation of financial sustainability, being a big one, and supply chain. As you can see in the next few slides the NSPS system of care tries to bridge these gaps with a strategy and implementation plan focusing on these core vulnerabilities.

The key features of NSPS are one is it's a very multidisciplinary approach. We've engaged more than 20 organizations through the development of the strategy and more than 70, almost 100 stakeholders who have helped drive and inform the NSPS strategy build up. Next slide. The drivers of NSPS strategy development have come from across the entire realm of health care delivery from public health policy, to emergency responders to academic institutions and
medical centers, frontline providers, health system executers, insurance peers and government agency leaders. Next slide.

We have five core aspirations. One is better care and to improve patient outcomes. Front and center of our mission is to make sure health care access, especially in special pathogens, is more equitable across the health care system. We recognize this current pandemic has magnified already existing inequalities in health care access, we need to improve allocation with more efficient response and better support for our health care workforce-knowing well that the frontline workers have taken the toll of this horrendous pandemic and may be traumatized for decades to come going forward. Next slide.

Our mission is to provide a coordinated and standardized health care network to provide high quality patient-centered care for patients suspected of or infected by special pathogens in the United States while maintaining health care worker safety at the core. Our vision, the aspiration of the system, is to save lives through a sustained, standardized special pathogen system of care that enables health care personal and administrators, to provide agile, high quality care across the health care continuum. And lastly, how would we know that have succeeded? We will know by these aspirational success measures that there were zero preventable deaths after a special pathogen infection. Mirroring very close to what the National Trauma Care System has in its aspiration measures. We would like to be able to mobilize a network very quickly, within four hours of when a special pathogen is suspected. And lastly, but very much so front and center, is that we want to preserve the same high quality special pathogen care across the entire United States population irrespective of which insurance mix or community you're coming from. We want to make sure to have the same access to high quality special pathogen care across the entire breadth of the population. Next please.

Along the same lines, we have six guiding principles. The future state of NSPS will abide by the following guiding principles: One is it has to be patient centered. Patient-centered care and outcomes will be front and center. We hope to improve on the current system’s coordination and collaboration, making sure that large health care systems are work with each other in a more collaborative manner. Responsive accountability, high quality and equitable care. Again, I cannot emphasize enough we have equity front and center in our approach here. Working in Bellevue, which is the premier institution for the largest public health system in the country, we have seen firsthand how underserved communities suffer the brunt of the pandemic of this nature. And lastly, scalability and sustainability. Scalability, so that we are able to handle a small number of viral hemorrhagic patients, such as Ebola, but able to scale over to a pandemic of current proportions, where hundreds of thousands have been killed and many more have been infected by this disease; so, scalability also is front and center in our approach. Next please.

We have a steering committee comprised of Dr. Lowe, Dr. Meta, Dr. Wagner, who is now retired, and me and helping us along the way is a talented core advisory group. We've had three tiger teams for framing the three pillars of this NSPS. A central body which we will talk about the expansion of the special pathogen network and a tiger team looking at financial sustainability. Knowing well that we want to avoid a boom bust cycle and have financial sustainability to preserve an NSPS that's distant from bonus funding that comes up of pandemic preparedness. We want to make sure that this is not reliant on a particular funding strategy and looking at multiple funding avenues to make sure it's sustainable. Next slide please.
This is how the preliminary conversations are going. Our strategy calls for expansion of the current network. The NSPS special pathogen delivered network has a proposal to make more reasonable Ebola and emerging special pathogen treatment networks, more geared facilities, where there are different avenues of being able to deliver care. In this NSPS-tiered special pathogen network is a core component of NSPS and that is a central body. It’s the glue that ties in this tiered special pathogen delivery network. Across encompassing this whole landscape from the financial options looking at not just legislation, but also at CMS options, at different mixes on how to make sure that special pathogens, which often are a financial disincentive, can be well funded going forward. Next slide.

And this is how we visualize the NSPS central body and how the care delivery networks tie into each other. On the right of your screen are the different tiers of care delivery network. We hope that Tier A, which currently would be mirrored close to the original RESPCT sites across the country have maximum capacity. Tiers B, C, and D have different forms of capacity and funding tied into them. On the left here is the NSPS a central body whose role is to enable coordination and standardization across the NSPS.

The connection between these two major players is reiterative and fit into each other. But the NSPS functions here to provide standards and guidance, monitoring, and evaluation, making sure that there’s research being generated from special pathogens activations. We want to make sure that there’s good patient movement and care delivery and this is reflected in our current endemic experience where we know that load balancing across systems, making sure that one particular hospital in our region is not disproportionately strained, which has such huge patient outcomes. We want to make sure that communication and coordination workforce and training are interlinked to each other. And, of course, funding is key, we want to make sure that even 10 years after this current pandemic has ended, we recognize that our systems need continuous funding to operate at an optimal level. So, this slide reflects that the NSPS central body glues together our delivery network, but also feeds in standards, guidance, monitoring, and evaluation and is the link between the different delivery network tiers. Next please.

Around four months ago, we delivered to ASPR the formal NSPS strategy and we’ve had multiple rounds of legislative education with key partners in Congress. We were extremely encouraged to see the House appropriations committee come out with the language that is as follows: “The National Special Pathogen System, the House appropriations committee recognizes that our national health care readiness capacity and capabilities were severely tested by the COVID-19 pandemic. The committee commends ASPR for establishing the NSPS, working with NETEC to set NSPS strategy implementation plan. To ensure coordination, the committee directs NETEC to serve as the coordinating body.” The House appropriations and the Senate appropriations are going under conversation about how much funding is available, but we’re hoping that there is some promise, knowing well that the current pandemic has exposed key vulnerabilities to our current system. Next please.

Our current status is that we continue to provide legislative education. We are focusing on triangulation of NETEC, RESPTC, RDHRS, and, as you heard from Dr. Hunt and Jennifer Hannah, we have a fourth RDHRS Center at Emory, and any new initiatives focused on pandemic preparedness, especially pathogen preparedness. We continue to work on NSPS or the next few months making sure that socialization is as optimized as possible and with the formation of the central body with key stakeholders playing on what exactly the central body looks like. Implementation will happen over the next two years. Next slide please.
We hope that by the end of two years, we come up with a much more robust pandemic preparedness plan that can handle pandemics, not just Ebola or viral hemorrhagic fevers, but also something with the magnitude of this current pandemic. We all believe that it's a matter of time before the next special pathogen hits our shores. We want to make sure our approach, the next time around, is equitable, and better prepared. And under Jennifer Hannah and Dr. Hunt’s guidance, we hope to have the resources to deliver on that. I’m going to pause and see if John has anything to add then open it up for questions.

John Lowe: Nothing to add here Vikram. I’ll just hold for questions.

Megan Wassef: Thank you both so much. It looks like we are short on time here, but if anyone has a question feel free to add it to the chat and we will revisit it towards the end. I will now pass it over to Andy Van Pelt and the GE team who will provide an overview of the new Oregon capacity systems tool.

Andrew Van Pelt: Yeah, thank you everybody. Appreciate it. We can move to the next slide. So, a little bit about Apprise, we are the subsidiary of the Oregon Association of Hospitals and Health Systems. Our customers are the 62 acute care facilities in the state, and we handle all the data and analytics for those hospitals and for the state of Oregon in regards to patient discharge financial and utilization. So that’s a little bit about us and why we're here today. Next slide.

A disclaimer: The views expressed in this presentation by me, and GE do not necessarily reflect the policies of HHS nor mentioned trade names, commercial practices, organizations- implied endorsement by the US Government or HHS and HHS is not responsible for the content of any external web page reference in this presentation. So that's the disclaimer saying this is not a sales pitch, but a talk in what we are doing here in Oregon. Next slide.

The vision here was an outcome and outgrowth of COVID-19. March 2020 obviously taught us a lot. In Oregon, we had no real data or center of data to understand patient flow and capacity within the health care system in the state, including for critical resources. At the beginning of COVID, hospitals were filling up and we did not have a system in the state that allowed for real time actionable data. It was all manual entry. We created a use case to pull folks together. In that a group of health systems got together and voluntarily agreed to create a bed capacity tool, which Jeff from GE will demonstrate in a moment, to stand up fairly quickly to provide real time data about capacity in Oregon’s hospitals. I give credit to OHSU, our academic medical center in Oregon, that allowed us to utilize their platform to develop. And here we are today looking backwards and seeing how something like this could replace the state’s current public health emergency reporting tool. In the midst of COVID, we also dealt with our historic wildfires that required us to evacuate five hospitals in a 24-hour period. Understanding where we could transfer those patients was critical in real time to work out all logistics. This is an idea to get a one health system view in Oregon for actionable data and again, one source of truth, which ties to the EMR and doesn't 100% count on human input, but a majority of fields will be automated. Next slide.
So, the project scope- We are in phase one right now. This new system will track beds by department and by hospital, vents, ED capacity. Currently right now we have about 200 patients in Oregon boarding in our emergency departments and we'll be able to kind of see some of that in real time. COVID flags we will know, down to the bed on a particular hospital unit, where a COVID patient resides. ECMO, CRT, and divert status or special status as a benefit to our EMS partners who are transferring patients around the state. All these features are planned to launch mid-December of this year. Phase two will be the complete replacement of the state of Oregon's current public health emergency system, which is 100% manual entry. The state is a partner in this development of this work, but this is a project of health insights and the governance of the hospitals in the state. There will be some manual entry just the nature of public health emergencies. As we know with COVID, things we weren't tracking yesterday we are now tracking because it identified itself as an important data point. We will allow for that ability. And automated PPE. This was a significant issue at the beginning of COVID, supply chain, where things were. We took those lessons and have a subgroup developing what the functionality and features should look like at the hospital level, to understand PPE inventory. Our overall vision is to make this not just hospitals, but the entire continuum of care within Oregon. We are beginning to engage with long term care and skilled nursing in terms of a potential phase three to understand capacity in those post-acute care settings. Next slide.

This is the secret sauce in terms of making this work from a trust standpoint collaboration is the governance of this work. There will be an appointed governance group of a diverse group of stakeholders that have a vested interest in this accurate information, EMS, public health, hospitals, other various entities. We are managing that policy development we have two subgroups PPE and Divert. Because it's important to create consistency across the state and definitions and reporting, feature prioritization no single person or entity wants to make the decision on what's important. The governance table allows for that debate and conversation in terms of understanding resource and value add for various features into the system. That is the conversation we're helping to facilitate. It also creates a level of decision making and agency and private sector relationship management. It allows us to work in a nimbler and faster pace versus a state agency. They are participants at the governance table, but we take on the responsibility of execution and then this ongoing post launch oversight and evaluation. Next slide.

So, this is how we've defined the governance steering committee in Oregon. As you could see it's representative. The way Oregon does it is they have regional resource hospital regions around the state, and we have identified the lead hospital in each region to be around the table. This is on purpose to align with the state of Oregon's public health response in these regions. And it has allowed us to again align with those objectives, but we've also added additional ones that are significant players in the state, especially region one where the Portland metro area is. This is the model we're using going forward. The state of Oregon is an advisor in this capacity as well as EMS. Next slide.

So, here's our timeline. As I said, the features around COVID, emergency room capacity. ECMO CRT and Divert our goal is to have that launch at the end of this year. Then we'll transition into the more kind of custom new features into 2022. Our goal is to completely transition from the current state reporting tool to this new tool in 2022. I think one point for this audience that is important is it's our principal or I should say the steering committee principle that we align as much as we can with the HHS reporting requirements that is our floor if you will, in terms of data
we will collect as well as how can we export, on behalf of the hospitals to the teller tracking system. One of the value adds, obviously, is to reduce the reporting burden. So those are all things we're considering and looking at as we develop this for Oregon. Next slide.

This is a diagram of how we're working with every hospital on a unique set of data specifications to tie into their EMR inventory and bed file to pull into the Oregon capacity system of which a prize is hosting and then will use end users, as you can see the hospital association Oregon hospitals and OHA to make decisions based on public health. One important point is it has no PHI, which is a huge barrier. We don't have to deal with in terms of data sharing as it is just counts and numbers in the system.

It's clear what the capacity system is. As I just stated, security concerns are very minimal, given the controlled access to the system it's obviously a user ID and password situation. We'll have various views depending on who you are, so EMS will have a different view than a hospital. Again, there is no PHI and every five minutes, the system pulls from the hospital EMRs and updates the system in real time. Next slide.

There's our contact information. Now I want to turn it over to Jeff Terry from GE who can walk through seeing the tool from where it is today. So, Jeff.

Jeff Terry: Thank you, Andy. I don't think we're going to screen share, but we do have some slides. The Oregon capacity system is a website accessed from any web browser. It's near time and automated meaning the information is updating every five minutes based on what's happening in the EMR. We've made it very painless for the hospitals to generate the extracts that feed this. Every five minutes we're not dependent on humans manually keying in something for this. Of course, meaning the data that is ingested here is created in the normal processes of care. Today the Oregon capacity system is live with beds and ventilators. Beds of all type adult need specialty, negative pressure, and we're adding all the things that Andy mentioned earlier.

You can see over to the left of the screen, where it says census, unoccupied, and capacity. You can decide to see how many resources are being used, which is the census; how many are unoccupied, which is available; or capacity, which is what is the total stock of those. Across the top, you can see the columns that are adult, pediatrics, and specialty. You're looking at how many COVID patients are in the ICU or how many are not in an ICU, and how many are over 65 or under 65. If you go to the next one.

It's a very easy modern website. We're showing the capacity by ICU level. We are not just saying ICUs, but we are saying what the real capability of that ICU. We've agreed to categorize all the ICUs in the state into one of four levels. One, two, and then three plus which three plus is really ECMO. Go to the next page.

So, what changes is the different columns of information that the user can turn on or off. In the upper right corner, you will see that the gear button it's very easy to manipulate and then to the left of that a search button, so you can search for your hospital. And if you go to the left from the search box you'll see where it says MSA region, county, state. It's very easy to filter by MSA, which is Greater Portland, by region ASPR or trauma region, which is the ASPR or trauma regions, by county, or by all hospitals in the state. One thing to call out, where it says County Baker or County Benton you see red and yellow areas. What that's doing is it'll alert on a hospital
that's high capacity and it'll also alert on a hospital capacity that is underutilized. You can filter and sort to try to find those matching opportunities. For anybody who's interested we get you a real proper demo. Hopefully that at least gives you some sense of what it looks like and how it's used.

00:36:48.900 --> 00:38:00.450

Andrew Van Pelt: I felt like we just rushed right through as a result of the agenda. Happy to take any questions around what we're doing here in Oregon. There is one question about cost of implementation and annual cost. That's dependent on the state or the use case for this; however, we were able to use our ASPR funds through the hospital association to see this program go forward and it is at no cost to the hospitals as data providers.

(Question) Additionally, there was a question in the chat about EMRs. Do hospitals all have varying vendors. Yes, they do. We are by far an epic state; however, we do have Cerner and some others, especially in our small rural hospitals that we are working with. GE can comment on this, but they are fairly agnostic to EMRs in terms of pulling data from. Is that correct Jeff?

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Jeff Terry: That's right fully agnostic. We will, based on the organization's EMR, give a specification to their report writer asking for it in the way their EMR works, so that it's easy, regardless of EMR, to generate the outbound data service to us. And we estimate for each hospital it's less than two hours of work per hospital per health system to build their outbound data services.

00:38:29.130 --> 00:38:39.540

Andrew Van Pelt: And I'll put my email in the chat for the website for this work and that's how I handle that. Any other questions?

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Jeff Terry: I see someone asked for an information page. I'll put a link to a one-minute video of the demo of the actual system for those that are interested.

00:38:56.520 --> 00:39:00.300

Andrew Van Pelt: Thank you very much, everyone.

00:39:02.130 --> 00:39:29.040

Megan Wassef: Thank you so much both of you for presenting and for that information. It looks like if no one has any other questions we'll move to general Q and A. Feel free to ask questions related to the NSPS presentation as well as any other general questions. As mentioned, you can ask your question in the chat or raise your hand, so we'll give a couple minutes for that.

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Jeff Terry: There's a question there Megan about semi-annual reports. I'm not sure if that's to us, or to another group.

00:40:11.190 --> 00:40:18.540
Megan Wassef: I believe that would be something that we can answer. Jennifer I’ll defer to you.

Jennifer Hannah: Sure, I know that there was a question regarding when the semiannual FFR be available in the payment management system and then as well as the programmatic semi-annual programmatic report. I’ll have to follow up with grants management regarding the question about the semi-annual FFR being available in the payment management system. They work more closely with that than I do. Then regarding the programmatic report, we will certainly follow up with some information.

Regarding the availability of that of that major report and will ensure that information is included in the follow up email with the with the link to the recording that will be sending as soon as the recording is available.

(Question) Yes, they were due on 10/8, but since we control the deadlines don’t worry about the particular deadline for the programmatic report. And we will establish new deadlines for that. Then as I said, for the semiannual financial report, usually it is a report that is automatically generated or becomes available through the payment management system, but I will follow up with grants manage regarding that component.

(Question) Is there a way to send push email regarding thing reporting notification?

That may be a little bit easier to do regarding the programmatic report, but since the pavement management system is controlled and admin by program support center that one is maybe a little more challenging.

Megan Wassef: Thank you so much, Jennifer. Any other questions before we close things out? If there are no other questions then, Jennifer, I’ll hand it back to you to close us out today.

Jennifer Hannah: Thank you Megan. At the same time, certainly want to thank our presenters for the great presentations and all of you for your active participation in today’s meeting. As a reminder, we certainly invite anyone to share stories regarding the hospital association hospitals as well as the any other health care related entity and what you’re doing with the ask for funding to make a positive impact on your community. If you have a story, please fill out the Stories from the Field or reach out to your field project officer for more information and a member of our team will drop the link in the chat for easy reference. We look forward to hearing about the great work you are doing and want to thank you for the for the work that you are doing. We know that the COVID response has been a very long response. Everyone certainly had a lot of work to do. We would be remiss if we didn't acknowledge all the great work. With that we're going to bring today's meeting to a close and give you back 14 minutes on your calendar for this afternoon. Thanks everyone and have a wonderful day.