Transcript for COVID-19 Office Hours

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12:30-1:30pm

Presenters:

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Hugh:

All right, it's 1230. Let's go ahead and get started. Good everyone and thank you so much for participating in today's office hours for providers. These office hours were established a couple months ago to maintain communication channels between DHHS leaders and providers about COVID-19 related activities. Next slide, please. My name is Hugh Tilson and I'll be moderating today. I think everybody knows but our office hour panelists are Dr. Betsy Tilson is our state health director, and Dr. Zack Moore, who's our state epidemiologist, and we're joined today by Allison Owen, who's the Deputy Director of the Office of Rural Health, and she'll give us an update on reimbursement for COVID related primary care services for uninsured individuals towards the end of our time today. Please join me in thanking Dr. Tilson, Dr. Moore for keeping these office hours. Their schedules are crazy, but they have committed to making sure you all have access to their thinking and their information and the opportunity asking

questions. So thank you so much for that. And I also want to thank everybody who's made the time to participate today. We know how busy you are and how important your work is. And we hope that the information you get today helps you navigate these trying times. So after Dr. Tilson Dr. Moore provide their updates, we'll turn to your questions. And we'll reserve time at the end for Miss Owens, I guess, to be a consistent update at the end. We'll then turn to questions. All participants are muted. So if you want to submit a question, there are two ways to do it. You can go to the email questions at questionscovid19forum@gmail.com. That's questionscovid19forum@gmail.com if you're on the phone, or use the q&a feature at the bottom. So let me now turn it over, I think to Zack, Dr. Moore.

Dr. Moore:

Yep. Thank you. Appreciate people joining. And I will start with an apology that I have to leave the call at one o'clock. But I know that Dr. Tilson will be staying on if there's more to discuss which there probably will be. So I will start off just giving you a brief perspective from DHHS side as to where things stand right now. So I think you're all aware that we've seen big increases in reported cases since the middle of September. So going on a month and a half now. And nationally, we just surpassed a new record in total number of new cases reported and unfortunately, in North Carolina, we surpassed the new record of new daily cases reported as well, today, coming up on 3000 cases a day-- new case reports. So that is very concerning.

We've also seen an increase in our reports of deaths, we've been averaging 30 to 40 deaths recently reported per day, related to COVID, which is, you know, been sort of increasing since about the middle of October now. We have fortunately not had big issues with hospital capacity, which is what we've been really focused so tightly on since well, really since February, at least, if not before. So we have seen increases in hospitalizations for COVID-19 but fairly level recently, sort of level at a high level, but level hospitalizations and intensive care units admissions for COVID-19 recently. So that's kind of the super big picture.

So it really just again, you know, it's fall, it's going into winter. So I don't think this should be a surprise to anyone. I think, you know, we might have all hoped it would not materialize. But I think the expectation has been that we would see an increase and unfortunately we know that everyone's been at it for a while and we we have routine communication with our local health departments and hear over and over again about COVID fatigue and people not being willing to wear masks and people sort of feeling like they need to put this behind them at this point. And problems with enforcement of control measures, required control measures. So we recognize that that's a huge component of what's going on, along with just cold temperatures, drier air, people being indoors, and so lots of work going on, on the communications and outreach front to try to address that. And that's, you know, a place where I know that your efforts in the physician provider community are really important to, you know, helping to convey the importance of protection and mask use and the three W's to the people who are looking to you for their information. So that's, you know, even more critical now than ever. I will say, you know, in terms of-- not going to get into the details on everything that we're seeing in our data-- we have seen a rise really across the state, geographically across the state and age groups, and race, ethnicity, pretty much going up in all those, but the bigger increases have been recently in the rural areas compared to the urban and suburban areas. And, you know, we're continuing to sort of look at that and try to target our messages, our resources according.

We have not fortunately seen, well, we have seen an increase in children. And as in all age groups, children, 0 to 17 remain the group with the lowest incidence of COVID-19. So that's encouraging, you know, we are getting school clusters reported. But there have, for the most part, been fairly small in number, and we have not seen any indication that clusters in school settings are driving transmission. On the community level, we've seen decreases in clusters in college and university settings, which is encouraging, although we do again continue to get to have issues reported from those settings. But I think there are, you know, emerging best practices in, you know, prevention in both of those settings. So that's that is encouraging as we go through this, continuing unfortunately, to see clusters in religious settings as a recurring or persistent theme. One of the places that people are being exposed along with just household and social gatherings. So I think that Dr. Tilson will talk a little more about our guidance for holidays and for travel. And I think that's a big concern for everybody with where things are right now, with COVID-19, and making sure that we do whatever we can to minimize increases related to that.

I did want to talk a little bit about influenza from a couple of perspectives, and we got some questions beforehand that I want to try to tackle here. One was just about flu surveillance and what we're seeing with influenza. So far, the news has been pretty encouraging. And we do posts-- a little bit hard to find-- but we do post on our dashboard, a surveillance update every week, that includes all the information from our normal, seasonal influenza surveillance summaries. So influenza like illness visits to emergency departments have actually been low. Lower than in the previous two flu seasons for this time of year. So that's encouraging and we are able to get a little bit of discrimination between influenza like illness and visits for COVID like illness, which is nice from a surveillance perspective that we've been able to tweak those surveillance systems to differentiate a little bit. We are seeing influenza in the state, you know, we did have our first flu deaths reported unfortunately. And we have seen very sporadic positive tests for influenza, we just got our first flu positive at the state lab. It's been very, very low, though in terms of overall detections of influenza for this time of year and at the state lab, and probably several other commercial labs, they're now doing multiplex PCR. So people who are being tested for COVID can be tested for flu at the same time, and still seeing low flu activity so far. So we hope that we will see the trend that they saw in Australia and South Africa and these other southern hemisphere countries that we look to for their flu surveillance data. We certainly would not count on it. But that so far, we've seen encouraging trends with low influenza activity. We did update our provider guidance, and there's a link on the slide that's showing now, the top link, provider guidance.

We had mentioned on this call before, finally, that we were expecting this and they, CDC, finally did come out with guidance about testing for influenza and COVID during this season. Basically just to boil it down, it's kind of split into patients who are outpatients and patients who require admission. So for the patients who are seen in the clinic don't require admission, the recommendation for people who come in with acute respiratory illness is to test for SARS CoV 2 , of course, that's been our recommendation for people with compatible illness for many months now. Recommended to do that with PCR test if possible, or with an antigen test if that's not available. And then the guidance on testing for influenza is to test if it will change your clinical management or your or your infection control decisions if it's a somebody in a long term care facility, etc. So if it's going to change clinical management, or change your other decisions to test for flu as well, using preferably, again, PCR test, but a rapid flu test or antigen test if that's not available. And then the guidance is also to prescribe antiviral treatment for influenza. This is something that we normally this time of year would be really banging

that drum. We haven't really had the opportunity with attention being elsewhere, but just emphasizing the importance of prescribing antiviral treatments, if somebody tests positive for flu, or if it's empirically indicated, based on their clinical picture and their risk factors. So if it's somebody who is at higher risk for influenza for any of the reasons that we probably are all familiar with, by virtue of age or underlying medical condition, reiterating the importance of antiviral treatments. And, yeah, I think that's pretty much it.

And then on the inpatient side, the guidance is that people who were admitted to the hospital with acute respiratory illness, the preferences for multiplex PCR testing, to look for influenza and for SARS CoV 2 and that if that's not available, PCR testing for those individual for those individually, should be used. And rapid antigen tests are discouraged for hospitalized patients. Although you know, for on the COVID side, antigen testing for the SARS CoV 2 can be used as long as a negative result gets confirmed, which is going to be the next thing I talked about. Just sort of the flowchart for considering antigen results in different settings. So that's kind of the influenza and COVID testing guidance in a nutshell, that is incorporated into our updated COVID guidance, guess that was pushed out at the end of last month, at the end of October. So if you haven't seen that, go take a look. There's also some other new information in there about a variety of things, the social gatherings guidance, antigen testing, etc. So that's probably all, maybe enough on influenza for right now.

And then, maybe if we can go yet to this slide here, did want to draw your attention to this lovely flowchart. And thanks to Dr. Scott Schoen, the director of our state public health laboratory for developing this. It's way more complicated than anybody would like for it to be. But that is not for lack of trying. It's just a complex topic. So this is our attempt. And I will say that North Carolina has put more out here than most other states or CDC to try to help guide this thinking. But I'll just walk through this really quickly. This is kind of where we are now in terms of how to manage different antigen or consider different antigen test results. So it starts up at the top with whether the person does or does not have symptoms. So for symptomatic patients who've had their symptoms for less than seven days, that's the left hand pathway on the flowchart, That's the news for which these are authorized under their emergency use authorizations. That's their intended use for antigen tests. And if an antigen test is done and is positive, then that's conclusive and that is considered a case and isolation and control measures should be taken accordingly. If somebody is symptomatic and negative, then that needs to be confirmed with a laboratory PCR test. So that's the guidance there. And you can see that if somebody does get the confirmatory PCR test, obviously a positive is a positive. If they're negative, that is negative. But if it's someone who has a close contact, then they still need to quarantine for 14 days. So, you know, at this point, we've still been emphasizing that you can't test your way out of quarantine, that may change in the future as we learn more. But at this point, anyone who's been exposed, considered a close contacts 14 day quarantine, regardless of a PCR antigen test result.

Okay, and then the middle pathway here is for people who have symptoms, but it's been more than a week since onset. That's not the actual use for which the antigen tests were authorized. So PCR test is recommended. However, if an antigen test is done, you would basically follow the same guidance that it says over on the left for less than seven days where you would need to confirm a negative result with a PCR test.

And then the right hand side refers to results when testing is done, and somebody who does not have symptoms. And this is really, increasingly how these antigen tests are being used. And you're

probably aware that there have been massive federal purchases and deployments of antigen tests, primarily not for use in diagnosing people who have symptoms, but for use in screening of asymptomatic people initially in nursing homes was the first kind of round of deployment for recurrent testing or screening, I should say, of staff. And then they've also been deployed to several other settings directly from the federal government, including historically black colleges and universities. We in the states received a lot of antigen tests from the federal government and have distributed those out to local health departments, who have in turn, been sharing those out with different entities in their communities. But increasingly they're being used for screening, which again, is not their intended use, according to their FDA emergency use authorization. But, you know, from the federal side, they've not only been encouraging us for that purpose, but also made it clear that people will not be penalized for off label use and that that's sort of expected. So we don't really have great data still on how they perform in screening for asymptomatic people. And it's probably not the same for all the different antigen tests, there seem to be differences for some of the different assays and how well they do there. So that's kind of why we've developed this here. So briefly, looking at a screening use and somebody with no symptoms, if they have an antigen test done that's positive in that situation. We would recommend that well, first of all, if they were, even without symptoms, that they're known to be a close contact that would be considered a presumptive positive. If they have a person with no symptoms, positive antigen test results, particularly somebody with no close contact or known exposure, that should be confirmed with a laboratory PCR test. And you can sort of follow the arrows long there. And I think that's probably about it.

I will say, and it's not on this flowchart. But a question that's come up a fair amount lately is about the point of care PCR test, which right now, I believe is the the Abbott ID now is the only one, in case any of you are in settings where that's being used. Basically, the guidance for antigen test here should apply to the point of care PCR test as well, because they, to date seem to have pretty similar performance characteristics with lower sensitivity than the laboratory tests. So this same guidance would apply in terms of when a confirmatory laboratory test might be needed there. Okay, so this is, again, posted on our website under the provider guidance section. And, you know, as we learn more, we'll probably be providing updated guidance as we learn more about testing with antigen tests and asymptomatic people. But just wanted to make you aware that this is a resource. And I guess, with that, I will stop and turn it over to Dr. Tilson.

Dr. Tilson:

Thank you. Appreciate that. And we wanted to front load that because knowing that he had to leave, and we knew there were some meaty questions that you all had submitted ahead of time. So I'm going to be pretty brief, and not as content heavy as Zack, so we can get to some of your questions. But a couple things I just wanted to highlight is updated guidance that we have in fact, including late breaking guidance that came out during this call. And so you may notice that the slide that is up now is slightly different than the slide that was up when we started this call. So I wanted to make sure you knew of some updated guidance.

So one, especially as we think about again, this fall, and then as we think about holiday seasons and breaks, we're trying to get ahead of that. And also understanding that a lot of our spread, or some of our spread, is smaller social gatherings, family gatherings, friend gatherings, we're trying to get ahead

of that. So one thing is, and this was we shared this two weeks ago, I believe, so this guidance isn't new. But this one to be sure, we had it up again that we do have guidance for private social gatherings. And basically, the point is that even if you're below the mass gatherings, any time any group of people get together, there is a chance of spread. So really talking through things that you can do to decrease the risk of a private social gathering. It is those same three W's-- nothing enormously different. But just reiterating that even in a smaller group, you want to be sure that you have the smallest group possible. You keep people six feet apart in the outside or open the windows. If you can wear face coverings, and also pay special attention to people who might be at high risk of complications. So thinking through older people or people with underlying medical conditions. So that is not necessarily new, but wanted to be sure you have that.

What is new, I believe is this guidance for safer holiday breaks. So this is geared to our college students, some of them who are on campus will be leaving campus and coming home. So this is geared to those students. And basically, it has advice for those two weeks before you leave campus, really trying to self quarantine as much as possible. If you are leaving a campus, whether it's active clusters, to quarantine once you are home, and then get through a lot of the three W's for students while they're home and on those holiday breaks. So you have that. In addition to that, and we've been talking a lot with our Institute of Higher Education administrators, what we are going to be encouraging and supporting to the extent that we can-- exit testing as well. So even we we were recommending testing for students if they were leaving a campus that that had lots of clusters or widespread transmission, but even students who are leaving campuses without that, we will be recommending or supporting or endorsing the concept of exit testing for students as they are leaving with all of the caveats that Dr. Moore just went over, that this is a screening test. Primarily hopefully asymptomatic in population, there are limitations. A negative test is just at one point of time. And so we have all those caveats. And we also have guidance if they're using a PCR or antigen. But we will be supporting that concept of extra testing as another layer of prevention, there's no single bullet, but layering kind of all these strategies with some limitation, we're hoping that adds a layer of protection. So that's some of the things we're doing with our Institute of Higher Education and working with those partners.

We also and this is what just went up today, I actually didn't realize it was gonna call this morning, I thought it was tonight or on Monday, but we have brand new hot off the press. Thanksgiving holiday and Black Friday shopping guidance, as we're heading into that. A lot of the Thanksgiving holiday guidance, you will see reflects a lot of the same language in private social gatherings basically the same thing. So you'll see a lot of that making sure we're protecting our high risk folks, the three W's. But there'll be a couple things. One is the idea of if you're planning a family get together of people outside of your households, thinking about that intentional two week self quarantine, before you are having that data group of people outside of the household. And then this is the first time in this guidance that we also are suggesting that to think about a screening test, before you are getting together with families. And so I think this is for the first time that we are recommending or suggesting a screening test before social gathering. So you will see that language in this Thanksgiving test. With all of the same caveats at the point of time, there's a chance of false negatives. That doesn't mean you shouldn't practice the three W's. But we will be suggesting a screening test before you get together. And this I think will extend as we think about this holiday season in general, a lot of families gather not just for Thanksgiving, but throughout December for different holidays. And so thinking about this concept of pre holiday get-togethers. People are going to get together, the holiday season is an important time, there are social

connections, it's important. And so this is part of our switching to a little bit of risk mitigation or a harm reduction strategy if people are going to get together, how can we add at least some layers of protection. So you will see that guidance for or suggestion of screening. And we are working with our state sponsored testing sites. They are able to do that for everybody without charge, we are looking into the CVS and Walgreens and pharmacy sites, they do have some more generous eligibility criteria that could work for the screening. CVS has a category that says that it's recommended by a medical professional. So if we're recommending it from the state, that could slip into that. And Walgreens has a category that says if you are from an area of widespread transmission, that would meet eligibility, and that is North Carolina. So there's ways that we can do it through our big pharmacy chains. We have had conversations with some of our big Urgent Care sites across the state and they can do the face and genetic screening. And then also having conversations with some of our payers just talk this morning to the medical director, they are our major payer about this concept of supporting some screening, no cost screening for their members as we head into the holiday season. So thinking about that as a policy change. The test itself should be paid for, but thinking through some of the deductibles and copayments. So we're trying to have those conversations with all of our stakeholders to make this as easy as possible. We're also trying to think about deploying our own testing, our testing vendors in ways that are really convenient for people. So thinking through people doing a lot of shopping. So could we do a testing site better at major grocery store chains? How is it that we can in New York City, what they've done is that they say that people just trip over testing sites, it probably got so many people to test because they just tripped over testing sites. And so we're trying to get those testing sites where people are-- at least our state sponsored one. So we have that out there, so want to make sure that you saw. And then this new recommendation is asymptomatic screening before you're going with family members. So those are all up there. Yep, I think that's it and everything else is the same from our last time. Oh, we're going to lose Zack in a minute. Shoot, I talked too much at them. But I guess I'm happy to take questions or maybe since we're gonna lose Zack anyway. Zack, you're leaving and you have to leave right at one right in a minute.

Dr. Moore:

Yep, I'm gonna have to drop off. Sorry about that.

Dr. Tilson:

Okay, no problem. So maybe we'll do that if we're going to lose Zack anyways, then Alison why don’t you go ahead and then talk to yours, and then I'll field the questions as best as I can without Zack.

Allison Owen:

Well, hey everybody, as Hugh mentioned, I'm Allison Owen. I'm the Deputy Director at the Office of Rural Health. And I wanted to share with you all a new service that we're offering through the COVID-19 CARES Act funding. It's through the NCTracks portal. So previously, some of our focus efforts for the Office of Rural Health have been to support the safety net system, but this new program is for

anyone who is enrolled in NCTracks or would like to enroll in NCTracks. So this is a portal that we built that will allow for primary care visits to be reimbursed for people who don't have insurance and they're living in North Carolina. And it could be a COVID related need.

So we recognize it gets a little bit confusing, probably with all the different initiatives that we have out through our COVID CARES dollars and through some federal dollars. And so we thought it would be helpful to create on one slide here all the different programs that we know of that are being offered. And you can see at the top there, we try to generalize these into three main categories. One, around testing, another around primary care, and another around operational, which would include some specialty care services as well. And I think our slide is a little bit stated at the bottom. But you can see at the very last one, that's going to cover testing and primary care. But I'm going to spend most of my time talking about the first one, which is the COVID related primary care services for uninsured individuals.

Now, this service is available, does not require citizenship verification, does not require social security information. So make sure that you recognize that because that is a distinct difference between this service and some of the other programs that are offered through different funding sources. Okay, so this is how it works. We had a portal built out through NCTracks, so that if you are enrolled in that system, and that's Medicaid reimbursement system, that you can go into the special portal and file for patients you have seen who don't have other means of payment. Now the reimbursement rate is $150 for each eligible claim. And it's available now through December 30. We have about $7.8 million in total for this program. And the portal launched, I think it launched last week. And as of yesterday, we had gotten 100 planes and the check writes will happen, I think weekly. So having a small uptick, we're trying to spread the word as often as we can. So you can see with the icons, what the program is, how the providers-- how you all can work with this funding and avail yourself of this particular program.

So the way it would be is if someone comes into your practice, and he or she either has a COVID related need or because of COVID is uninsured. Maybe this person lost their job or lost your health care insurance because of layoffs and downsizing because of COVID. So this person could qualify for this program. So part of what you already do is make sure that there's no other health care coverage that this person would be eligible for. And then go in through this portal, through NCTracks, you can file this claim and receive $150 per encounter. And that's important to note it's for encounters. You might have several procedures that you identify with that visit but it's not for procedure or per service, it's for encounter. You'll see at the bottom of the screen, the attestation statement that will have to be checked before you can proceed and NCTracks with processing the claim. So making sure that you as a provider haven't gotten any other assistance and that the individual hasn't gotten any other assistance.

And we're also partnering pretty heavily with a community health worker initiative that's going on in 53 counties across the state. We're helping our community health workers to spread the word about this so that if they come across an individual who would qualify for this service that they can link the individual to your practice, and make sure that you can get this reimbursement. So we're asking our health workers to look at the webpage and make sure they're up to date. And you as well, and encouraging folks to seek this primary care because one of the goals with our community health worker initiative, is to make sure folks have links with a primary care provider if they don't already have one. And then as a provider, as I mentioned, if you're not enrolled already, in NCTracks, there's enrollment that you can access through the portal. If you're already enrolled, no additional steps and you'll see this

particular portal when you go out into NCTracks. And we have some links to help walk through that process. There will also be some training opportunities that will be available. Starting next week, I think we have 4 different webinars and training sessions. And those will be recorded and available as well. I think that's it for now, just a very high level overview of this service that's going to be available. And I think we can take questions.

Hugh Tilson:

Thank you, Allison. So far, we have two questions. Just a reminder, you can submit questions either using that q&a feature or the Gmail. First is really more of a comment, which is Thank you, Dr. Tilson and Dr. Moore. So want to emphasize that-- appreciate your time very, very much.

Second is for Allison, are virtual visits eligible for reimbursement?

Allison Moore:

Yes. And we follow the guidance that North Carolina Medicaid has set forth for virtual visits, and COVID.

Hugh Tilson:

Great, those are all the questions we have. So let me just remind everybody that if you want to submit a question, now's the time to do it. Otherwise, we'll free up 24 minutes on everybody's calendar. All right. Why don't we free up 24 minutes on everybody's calendar? Allison And Betsy, thank you so very much. Is there anything you want to chime in before we let everybody go?

Allison Moore:

I just thank you for your time today on a Friday. And if you have specific questions you can email me. There's all sorts of information on our website, as well as on NCTracks website. So the declining balance, I mentioned, is 7.8 million for this program. $150 per encounter. And that'll just be a declining balance that should be updated about once a week on that website, and you'll be getting some email notifications as well, just as a reminder that this is a resource for you.

Hugh Tilson:

Thank you. Betsey?

Dr. Tilson:

Um, no, I don't think so. I think just that we all need to be pretty vigilant as we head into the fall and the winter. I think we are seeing our numbers go up. Now, some of it I do think is because we are

testing a lot more. But I do anticipate we are going to see more as we head into the fall in the winter. So just I know, it's really hard to continue to think through the mitigation strategies and prevention. Everybody, myself included 100%, is very fatigued with COVID. But I think the next couple months are going to be really, really important. So whatever you can be doing to be emphasizing the importance of the prevention strategies, continuing to push out the guidance, sharing the guidance, I think right now, our best tool is prevention. And so as much as you can be the voice of prevention for us, that'll be great.

I think we're still a ways off for widespread vaccines. I don't see that being really enough to help with our herd immunity until the spring. So this winter, it's going to be all about prevention. So helping us do that. And then the good news, as Zack had said that I think all the prevention stuff we're doing for COVID. Hopefully, knock on laminate wood, may make this less of a bad flu season, which will be really helpful because if we have COVID and flu, our health care systems will be potentially overrun. So as much as we can do that.

I'm gonna say a couple other things if we have time since we have questions. So a couple things. Also thinking through the flu vaccine. To continue to encourage and promote the flu vaccine as a way we can lessen the impact of the flu season which will allow for health care capacity and get us through. The other thing, and I should have mentioned this proactively up front and I apologize, that we did extend the deadline for the child and adolescent immunizations. For the deadline for documentation before there was exclusion from school. We found the immunization rates were pretty low, we had a record number of kids who are not in compliance. We did a survey out to our local health districts, and we were getting back, this is the worst we've ever seen. 2x, 3x, 4x the amount of kids who are not meeting the requirements. A significant proportion, but not all, by any means is the new 12th grade meningococcal vaccine. I think we talked about this the last time, not exclusively this, but that is definitely playing into this. For the districts that did break out the 12th grade from the rest of it, it ranged anywhere from 13% to 60%. of the kids that had not met the requirement were attributed that were 12th graders. So certainly not 100%., but this is definitely playing in. So we did extend that deadline for two months. But I really, really, really, really don't want to extend it again. So whatever you can do to get those kids in for their routine vaccines, and especially the adolescents. I know there's limited adolescent visits, they take longer, chalk up more time, sometimes it's hard to get to adolescence in considering just doing adolescent immunization clinics. Just getting them in for that vaccine, and then rescheduling them for a physical later. I really worry about those seniors and will it jeopardize their graduation if they're not up to date and have to be excluded. So please, please, please think about ways to get kids up to date. I know that AHEC and CCNC-- I think Tom's on-- and our Medicaid program are all working on that. And forgive me, and our immunization branch and DPH aree're all working on that. But we really got to get those kids up to date, because I really don't want to have to exclude them from school. This is the last time that we want kids out of school. But we also don't want our kids unimmunized. So please.

And Hugh, perhaps I could open the floor to you to talk a little bit about maybe some of that, and what AHEC is doing and some of the support around that. the keeping kids well campaign and some of those supports. Could I just launch that on you to talk a little bit about that?

Hugh Tilson:

Absolutely. So we're partnering with Medicaid and state and community care to do the keeping kids well campaign designed to increase immunizations, working with practices. We've allocated them to get out. So looking at care gaps and identifying practices where some targeted intervention might be helpful and reaching out and trying to figure out how we can help to bridge those gaps. That's all I've got right now.

Dr. Tilson:

And then maybe as part of this link, there were some really, really nice patient files and handouts and graphics and stuff that maybe we could include as part of resources for this meeting as well. And in the chat box. There's some really nice graphics and tools that have been developed for that, but just want to make sure that that's on everybody's radar.

Hugh Tilson:

We can add that link. All right, thanks everybody.