Transcription for Friday Office Hours for Providers
December 18, 2020
12:30-1:30pm

Presenters:
Betsey Tilson, MD, MPH
State Health Director
Chief Medical Officer
North Carolina Department of Health and Human Services

Zack Moore, MD, MPH
State Epidemiologist and Epidemiology Section Chief
Division of Public Health
North Carolina Department of Health and Human Services

Maggie Sauer
Director
Office of Rural Health
North Carolina Department of Health and Human Services

Hugh Tilson:
Let's get started. I will be brief today. You can see who the speakers are-- we're excited that Maggie will join us to talk about reimbursements for uninsured folks after Dr. Moore and Dr. Tilson jump at 1 PM. We will take questions, you can use the Q&A at the bottom of the screen or send us an email questionscovid19forum@gmail.com. We will get this recorded and we will mount the recording and slides on the website first thing tomorrow. After that, thank you to everybody for joining us and thank you for carving out some time in these crazy times, and now I'll turn it over to Dr. Moore.

Dr. Moore:
Great. Thank you. I will take the opportunity to say that this is an incredibly distressing week and an exciting week. We are finally able to start utilizing the tool that I am confident is going to be the game changer in the entire pandemic response which is beyond exciting. Vaccines are the reason I got into public health and overseeing this development and launch is really encouraging. Dr. Tilson will talk much more about that as she has provided a tremendous amount of leadership on the state response which I think has been really exceptional. There will always be bumps in the road with something like this but I feel like we've had a first week that is really great.
With that said, we've not had a great week with actual COVID transmission. We are in a very worrisome place in that regard. Just today, we have added almost 8500 new cases in a single day which is a record for us. And we have unfortunately seen close to 100 deaths for a single day reported also this week. So it's just a tremendous amount of virus out there as we enter into the holidays. Our hospital capacity continues to be a huge concern. We have seen increasing hospitalization numbers and ICU numbers and COVID admission numbers. And we recognize the strain this is putting on many out there in the healthcare settings and just what a critical moment it is even as we embrace the vaccine and appropriately shift our focus to using that to its fullest extent that this is absolutely a time when we need to be maximizing our prevention messages and doing everything we can to make sure that people make it through to be able to receive the vaccine. We do recognize that we are coming into a period where, despite our best guidance, there will be a lot of gathering and opportunities for transmission. So we are doing our best and I appreciate all of the folks out there, the healthcare providers who are the most trusted listened to source of information,

much more so than the state governments. Thank you for your help in getting these messages out that we are at a very precarious situation and we have a lot of good holiday guidance that is up on the website and I hope you will really be pushing that and encouraging people, first of all, to not gather with people outside of their household and not travel over the holidays. If they do decide that they are going to be gathering or traveling, and we certainly get that some will. And as the secretary has said that abstinence only education does not work, so if people are going to be gathering with others, we have guidance out there that I think really breaks it down in a very digestible way about the importance of consistently masking when you're with people outside of her household. Doing whatever you can do outside. I'm watching the weather and Christmas does not look pretty for that, but keep it small, keep it outside if possible, keep masks in place, get tested before gathering with people outside of the household, and consider testing afterward if they have been exposed to people outside the household so we can try to cut off as much of the transmission as possible. But we do recognize that we had a huge increase after Thanksgiving and we had a huge increase before also so it is very concerning. We are heading into a situation where we will have 10,000 new cases a day or we could easily surpass half 1 million cases cumulatively by the time we get to the end of the year. As we know it would be, sort of darkest before the dawn type of situation. So I just want to really drive home the importance of the prevention messages, even as we are all pivoting to find our place in line and our patient's place in line to get the vaccine and make sure that we are on the mark ready to do that and just really I want to reiterate the importance of the prevention messages that we have been trying to hit on since the beginning of this. Tired as we all are of hearing them. So I think that is probably about all I will say in interest of leaving time for vaccine discussion. Now for Dr. Tilson.

Dr. Tilson:
I want to reiterate that point. I know it's all about vaccine this week and that is exciting. But I hope you are following the numbers on our dashboard. They look scary. I don't think we are at the peak. We are very worried about hospital capacity and very worried about people dying. So although we are weary of it, this is critical. We will not be able to get enough vaccine in enough people to prevent people from dying in the next couple of weeks. So it is really critical. I do know it's all about the vaccine right now but we cannot take our eyes off of the prevention ball because vaccines will not help us in the next couple of weeks, and I am quite nervous about what the next couple of weeks look like. So we really have to double down on that. We really have to double down on our holiday messaging. We did see a surge after Thanksgiving. We can make sure we have the link to the holiday guidance as well and make sure we are stressing that. We are nearing the end but we are not there yet. And the next couple of weeks are really going to be critical. So please help us with that message. A couple of things, some proactive comments about vaccine and then I can answer some of the questions and we can also forward you a link to give you more tangible, concrete information. On the exciting news as probably you all know, but we know that Pfizer received the FDA EUA last Friday and it was recommended by the CDC advisory committee on immunization practice on Saturday, over the weekend. Really excited about that. So within 24 hours, we had vaccine in North Carolina. So this was week 1. This is only week 1 of what will be a many months process. We will get better with making it more streamlined. We will get better with communication. We will get better in having people understand where they can go. We will get better with logistics. Remember this is only week 1 that happened within 24 hours of some of the information we needed. So we are still very new in the game. But it was really exciting that this week we were actually able to get vaccine into some people's arms. So it's incredibly exciting. And then with Moderna-- you probably heard that the advisory board for the FDA yesterday recommended that the FDA authorize Moderna. I expect today, perhaps even as we speak, that the FDA will accept that recommendation and FDA will issue an emergency authorization for Moderna. Then CDC ACIP will meet this weekend, much in the same way they did last weekend, going through recommendations and giving us clinical guidance and we will turn that around within 24 hours as we have Moderna start coming into the

state next week. All the authorizations and recommendations have to happen, and I expect it will happen, but you never know. And then we will have Moderna be able to come into the state next week so we are excited about that. The turnaround time, the allocations, we have been working on it to try to make it as good as possible. But we will get better as we move on. Just a couple of kind of clinical things with these two vaccines and you all probably know that those are based on the messenger RNA technology. So in general, we are finding the effectiveness is pretty equivalent for them both, very high, a little bit of subtle differences in looking at the data from Moderna and maybe a little less effective in older people whereas Pfizer seems more consistent. And then on the temporary reaction side, there might be a little more temporary reaction, so the headache, fever, swelling with Moderna than Pfizer. It's a little bit more like that but we will keep looking. A couple of things, though, is one, as we are looking forward, it will be a point for people to understand that there will be a relatively high rate for both of them to have temporary reactions and people should expect that. And not think it is a serious adverse event. I think that will be a really important piece. But the other piece that we have been learning a little bit with Pfizer is the issue on anaphylaxis or serious allergies. That was not detected in clinical trials. Now as Pfizer is being rolled out and we've seen a couple of cases, three in the UK, two Alaska, so there is a contraindication from the FDA EUA that any person who has unknown anaphylaxis to the ingredients in the vaccine, it has a little bit of the messenger RNA as well as four lipids, the hypothesis right now is a polyethylene glycol in Pfizer but we are still discovering that. That is a contraindication. And then the warning from ACIP is anybody who has had a serious allergy to another vaccine or another injectable, there is a warning. And so with Pfizer, there is a clinical recommendation that people must be watched for 15 minutes after the vaccine and if they have a history with anaphylaxis, they need to be watched for 30 minutes. That was one of the questions that had come in, the safety in terms of the allergy. With Moderna, so far, in the clinical trials, we have not seen any of that anaphylaxis. But again, it did not show up in Pfizer's either. So I think as we rollout Moderna, we can see if that is an issue with that vaccine as well or not. The Moderna vaccine has that messenger RNA but a slightly different lipid. We will have to learn about that if some allergies extend to the Moderna vaccine as well.

Just a little bit about allocation, where it's going the first week or two, because we've got a lot of those questions and then I will talk a little bit about the timing of broader provider enrollment, timing of CVS, and a little bit about the definition of 1A and what outpatient providers might fit in 1A and how they can get access to the vaccine in 1A before we have more broad provider enrollment and then enough vaccine to do more allocations to a broader set of providers. So right now with our very first week 1 allocation, all Pfizer, it did go to 53 hospitals across the state. Week 2 allocation which will include Pfizer as well as if authorization goes through, it will also include Moderna. Week 2 Pfizer is going to go to a smaller number of hospitals because we got less Pfizer for week 2 then in week 1, so it will be a smaller number of hospitals as well it's going to go to some of our larger health departments that have the capability and storage. So some Pfizer will go to health departments. In Moderna, the way the federal program works is there is a long-term care pharmacy program that will then start vaccinating people in the nursing homes, skilled nursing homes and other long-term care facilities, they will be using Moderna. So a big portion of our week 2 Moderna is being redirected to that long-term care facility program, starting with nursing homes. The remaining Moderna that we did not have to allocate over to the nursing homes will go to the rest of the health departments. We have three health departments getting Pfizer and the other 97 getting Moderna and some smaller rural ones that weren't able to get Pfizer. We should have at least some vaccine in every county in week 2. That's where we are with weeks 1 and 2. We do not have any more information on week 3 or 4, other allocations looking forward. What we do know is that for every first dose, these initial treatments were first doses, we know the second dose you need is being held by the federal government and we will get the second dose. We know that. But we do not know about any other additional allocation above that in order for us to plan how many other providers, how many other points of distribution can we push out because we do not have numbers beyond next

week. I want you to know that. As of next week, there will be vaccine in at least every hospital and at least in every health department.
The question that we get is if I am not affiliated with the health system and I am in 1A, how do I get access to the vaccine. A couple of things we've done this week as we have been sorting through the first week craze. One is that we are being more intentional about language about how an outpatient provider might be able to fit into 1A. And so what Nevan has on the slide is a link to the FAQ on our website that talks about the outpatient providers. There is a whole host of outpatient providers. Outpatient providers that have an increased risk of exposure than a typical outpatient provider, meaning there's a lot of outpatient providers that would not necessarily have a lot of exposure to patients with COVID-19. So an outpatient provider with increased risk of exposure and that means outpatient providers who are focused on COVID patient evaluation, respiratory care, diagnostic centers, members of a dedicated respiratory care team, frequently involved in COVID testing sites, so a little bit more clarity on what kind of outpatient provider who may have a lot of potential exposure to COVID patients because they are actively involved in respiratory care. So that language is there on FAQ. And also a little bit of direction about if it applies to you and how do I operationalize that. And so what is on FAQ is that as a healthcare organization or employer, you then would decide who amongst your staff meet that criteria. It's really the front-line people that are really working day in and day out with those patients, and then coordinating with either your local health department or hospital who has vaccine to see about the availability of vaccines through their clinics. On the other side, we have the same messaging to our health systems and health departments so they are aware of this. The health department will know they will be opening up to other community providers but also make sure that the health systems open up to community providers to make sure they are aligning with the 1A requirements, being very consistent with the requirements, and if they are extending outside of the inpatient COVID units to more outpatient, to use that consistent definition and to open up to community providers with that same definition and to allow for committee providers as well. So that's all in the FAQ. We have communicated that to the health departments and health systems that we will send out written guidance that way and you have that. So we are trying to make that more clear, more granular, and have clarity and expectations on both sides on how it is that we can be sure our 1A providers are identified and have access to vaccine.
Another question we get is when can I enroll as a COVID provider and when can I get trained on CBMS. So the first thing I want to say that CBMS, we are in that minimal, viable product. We stood the system up in about six weeks. There are a fair amount of kinks in version 1 that we are really needing to work out before we can really open it up to the full range of providers that we definitely want to enroll. The system is fragile right now. It is not ready for that big onslaught of providers that we want to enroll. We want to get there absolutely but we need to shore up the system so the team is working 24/7 to make sure we can stabilize the system and make sure that it is working and functional. So what we anticipate is in the beginning of January, the first week or two, the system will be stabilized enough and we can open it up and we can do your provider enrollment through CBMS and as we get vaccine, we will be able to distribute it to you and you will also be doing all of that data, all of your data entry and tracking in CBMS so just be a little patient with us. Give us maybe two or more weeks to stabilize the system so we can start opening up provider enrollment. I also want to set expectations, just because we get you enrolled does not mean we will have enough vaccine to be able to push it out to all of our enrolled providers. It will take a while but we can at least start the process of getting you enrolled, getting you trained in the beginning of January. In the meantime, we have this more granular definition of outpatient provider and that working with your health system and health department who are the only ones with vaccines right now in the counties. We are working on that and trying to gain access to that and being consistent with the definition of 1A.
A couple other questions we were asked, **do we have a choice to which vaccine we receive?**

In the beginning, no. We will see how much we get as we get more and more. What we will try to do is only give one vaccine to a provider so it will be a lot easier and you are sure of your patience coming back and getting the same vaccine. We don't have clarity on how much we will get on which vaccine. What we would like to do is get a lot of Moderna because it will be a whole lot easier out in the community. It only requires a regular freezer and comes in the amount of 100 and lasts longer-- it will be a whole lot easier for folks to use Moderna so we hope we get a lot of that. But we also know there are sites across the state that have ultracold storage which is great and I got a list of providers this morning that have permanent ultracold storage on their sites and that's great. So the ones that have that, it may be that we then distribute Pfizer to them because they have the easier ability to store and then Moderna to those that don't. You do not have to have permanent ultracold storage to get Pfizer, it comes in a shipping container, and if you refill with dry ice every five days, it can last 30 days which is good because it comes with 975 doses. The Pfizer minimum is 975 dooses. You do not need to have permanent ultracold storage. You just have to have a way to vaccinate 975 people and keep it at that storage and be able to replenish with dry ice every five days if you cannot get 975 people within five days. So it's a little tricky and so as you go through the provider enrollment, you will see we ask you about your storage capability is, what's your throughput, how many people can you get, what is your storage looking like and it helps us match make what vaccine is better to go to what provider because we have a better sense of exactly how you can actually store and what your throughput is. So at least in the beginning, I'm not sure we will have the luxury of choosing. Between us, what do you think you can store and can you handle 975 doses? In the beginning it will probably be a matchmaker situation. I'm hoping as we go down the road and these decisions will get easier and easier and we will have time but we will see.

Generator capability to be a vaccine distributor, so I looked at the provider enrollment in anticipation of this and it does not explicitly say you have a generator but it doesn't say that you have to be sure that you can maintain the storage requirements.

How will the community be notified that they need to register in the patient portal before receiving the vaccine? That's a really great question. It is something I hope will not be necessary in the future. Right now in the minimal, viable product, it's true you have to register and it's by email. For some of you, you probably saw that your employer or someone registered you and you got an email. You had to register through that email, through a portal to get scheduled. That's not going to work as we scale out. That will not work in community-based settings and in health department settings. So in the version 2 which we are hoping to be able to launch the weekend, with a little bit of the kinks we are working on a version 1, we may not be able to do the update this weekend and it might have to be next week. But a really really really important upgrade that we want to be sure is there before we roll it out more generally is no longer that requirement for people to have to register via email. It will be like a walk-in, we call it the walk-in function where people can walk in and schedule and it will not be dependent upon an email or patient portal enrollment. That clearly will not work with a population or people without an email. That is very high up on our version 2 and we hope it is in place either this week or next week so you will not have to notify people to do that because that will not be a requirement. As I said, we are trying to do a lot of updates for CBMS which is why we are trying to stabilize it to do the upgrades, then we will be able to more easily enroll our providers more quickly but we have to stabilize the system a little bit more. And since unfortunately we do not have a lot of vaccine over the next couple of weeks, it doesn't mean we can get vaccine to you so I am sorry for that. We would rather enroll you in a system that is less frustrating for you than enroll you in a system that is going to frustrate you one day 1 and still will not have a vaccine that can be given to you that first week in January.

A couple of other questions about plans to keep community vaccinations orderly. Yeah, and especially our large vaccination clinics, some are actually working with our National Guard and some with emergency management to do some of that crowd control and I think that will be site by site as we move forward.

So I think I actually answered a lot of those questions that came in that overview. I don't know if other ones have come in as I have been talking. I will be happy to answer because I have a couple of more minutes before I have to drop off.

Hugh:
So you have answered most of them directly or directionally. I got a couple of questions that are more for Zach. I will remind everybody that you will hold open office hours on Tuesday night and there's a link to that in the slides so we can drill down and I will forward all of these questions to them. **But Zach, do you have one second to talk about what are your thoughts on the change recommendation from CDC about the quarantine period from 14 days to 10 days or even 7 days. There are some angry parents wanting their children to return to school sooner. We had been recommending the 14 day period with exposure.**

Dr. Moore:
This has generated consternation. The vision of course was that there would be better compliance with shorter quarantine. That was part of the vision that this would ultimately lead to reduced transmission because there was so much concern about people being willing or able to actually quarantine for a full two weeks, so that was kind of the logic behind it. But the CDC language and our subsequent guidance to the local health departments was that 14 days is still the baseline and default. Local health departments can determine in what situations it might be appropriate to have a shorter duration of quarantine. So I think it's fine to recommend that people stick with 14 but yes we also understand that people are aware that there are shorter options out there and they may not be willing to do that. I guess I would say, the only settings where we've kind of drawn the line that we do not recommend considering those is settings where there's a high risk for secondary transmission or where there is a population of higher risk for severe illness, like at nursing homes and correctional facilities, that type of thing. So out in the community, these options are out there and I guess all I would say about it is I think if it is determined that a seven day quarantine is appropriate, it's important they understand they get a test, a specimen collected after at least on or after day 5 after exposure that is negative and then even with that negative, they cannot end there quarantine until they have completed the seven days so that one is a little bit tricky. I think people have been more using the 10 day option. But yes, I do not know if I have anything else specific on that. But I recognize that it does create a lot of challenges and a lot of expectations from the public that they will be able to quarantine for a shorter time.

Hugh Tilson:
I know you guys have to get on a 1 PM briefing so thank you so much for all you are doing.

Dr. Tilson:
Thank you for your patience as we work through week 1 to figure out how we can get better for week 2 and 3. So we know there are a lot of questions and everything is not perfect in week 1 so we are working every day to make it better so thank you for your patience and grace and partnership in this as we move forward for the biggest and most complex mass vaccination campaign ever in the midst of surging hospitalizations and cases. So thank you for being at Ground Zero with us. Our commitment to you is even if we are not perfect on day 1, we'll keep trying to get better. Thank you.

Hugh Tilson:
I will forward these questions to you as you prepare for Tuesday.
So we wanted to do a couple of quick updates before I turn it over to Maggie. First of all, I think you heard that there will be office hours Tuesday night for more information on vaccines. So there is a link on the NC AHEC website for that and you should be getting emails. If not, let us know.

Secondly, we were not able to process many of the questions that you submitted. I will forward those to Dr. Tilson as she prepares for that webinar. And hopefully that will help her to be prospective to those. There are links to the website that I put up earlier to the vaccine page. You can get this deck on the AHEC website and link to it there. And lastly, I talked to Dr. Tilson this morning. She has committed to this communication and will continue to have office hours as long as you all think they are helpful. We will start getting them on the books for next year as well. Please know that they recognize the need to provide timely information and want to use this forum if it's helpful. Those are the housekeeping things I had in response to the vaccine and that portion. Now over to you Maggie.

Maggie Sauer:
Thank you everybody for everything you are doing to keep North Carolina safe. I know you've heard about this program in the past. I'm just here to urge you that if you have not been able to make use of it, folks have not been able to, they have not processed claims and those kinds of things. We are, as of December 30, running into a funding cliff.
The opportunity here has been to try to get people covered for care regardless of whether or not they can attest to being a citizen. And making sure they get tested, primary care, and any number of things. So this slide lays this out for a number of programs that have been available across the state, particularly the one we are talking about today is the first one. It is the COVID-19 related primary care services for uninsured individuals in North Carolina.
There is a requirement utilizing this portal. It is for kind of the payer of last resort because in every other case, for instance, in a HRSA portal and others, you have to attest that basically you have tried every other place to get a visit paid for and have not been able to do so. So this is a very easy way for people who are uninsured to get their care paid for. The optional COVID testing program, something in the second option that is a little bit different in the primary care uninsured portal is you really do not have to attest that someone is a citizen of the United States. So it gives people a little bit more option for some of those payments even in testing. But obviously, if people can attest to that then the Medicaid option is the best. The Health Resources and Services Administration, talking to some of our friends and colleagues in Washington D.C. and understand that there is some complications and difficulty that people have experienced in terms of getting reimbursed, getting through the portal, and those things, and we certainly understand that, so I hope that does not prevent people from being interested in using the uninsured individuals support we have for the state. The Medical Society rocked it out. They had $25 million. And as I understand it, that fund has been completely evacuated, if you will, and has gone out to a number of practices that needed that support. So that is awesome. I'm really glad to hear that people have been able to get relief with that. And then of course there is the provider relief fund payments that others have been utilizing for other kinds of payments and care.
In North Carolina, just to dig a little deeper, and I know many of you have probably heard about this before, but what we wanted to do was to build a program that looks a lot like NC TraCS. That people would have experience within NC TraCS so that it would not be as overwhelming as building a separate portal, for example, like what HRSA has done separate from CNS. So you know, I think what we have tried to do is build on that infrastructure and we are really trying to distribute reimbursement funds to primary care providers quickly. And so the reimbursement is $150 for each eligible claim. What that means is that it does not have to be for the entire episode of illness, but every time a patient comes to see you, it is $150 for that visit. So if someone has complicated issues related to chronic disease, a number of things, it is $150 per visit. And to emphasize the point that December 30 is the very last day claims can be submitted, I really want to emphasize to folks to get those in sooner rather than later. I am not sure if people are holding claims until a bit later. We would really emphasize that the program can pay providers for those visits that occurred from September all the way forward.

What does this mean? It is a related service that includes follow-up appointments.Confirming that the individual has no other healthcare or health insurance. And you will see at the bottom of the screen that there is an attestation statement. Basically what we have been required to do with these funds, with the CARES dollars, and I know many of you have been living through the processes as well in terms of what the requirements are and also the ability to audit and those kinds of things. So we had to include this attestation statement at the portal to ensure that these other sources that have been developed federally or that someone has insurance, etc, have been tried before utilizing these funds. And so the things we typically think about, and I think with this fund in particular, you do not have to test positive for COVID to use these funds. It can pay for testing. Again, if the Medicaid portal is not the way to pay for testing because, for whatever reason, someone cannot qualify for that, but it can be if people, you know, I have heard these numbers of folks who are uninsured in the state now as a result of COVID and it has doubled. So when you look at people who may be your patients, who had at one time medical coverage, but because of COVID, they lost their job. There are other family circumstances that they do not have coverage, those are the things that can help people qualify for this payment. And so you look at the marginalized populations that may have a higher risk of chronic disease. And so again, it is trying to make sure that people, even if they do not have insurance, they can get to a medical home and be treated for even those conditions that are related to the increased susceptibility to COVID.

So I think the things that can happen, particularly with the community health workers that have been discharged across the state into communities, there is a really lovely opportunity for them to work with people who are working directly in the community to get them to practices so that they would be able to receive the care that they need. And so I do not have a good sense of how many of those patients who are working with our community health workers at this point have been able to achieve creating a patient centered medical home or a medical home for some of the folks in the community that they have been involved with. I hope that some of you have been able to interact with community health workers and create that access. I just want to say again that if you are enrolled in NC TraCS, this whole system should be known to you or familiar. If you are someone who has not signed up to NC TraCS, you do not have to be a Medicaid provider to sign up for this portal. If you are already enrolled, that is great. If you're not enrolled because you have not necessarily provided Medicaid in the past, you can still complete the enrollment and also gain access to the funds necessary to pay for patient care through the uninsured portal.

On each clickable link, there's additional information about opportunities to use these funds. When you go to the uninsured portal link, there is actually a training video there. Also we have held a number of trainings across the state in recent weeks. And a number of the folks who have attended those trainings have been practice managers and others are related to this care. So if there is anything at all we can do to assist you or your practice in utilizing these funds, we do not want these funds to go unused and so we really would encourage people to utilize these funds to serve your patience. And like I said, I want to emphasize, if there is anything we can do to reach out and answer questions, we are definitely wanting to make sure that it happens.

Hugh Tilson:

Thank you. You can submit questions to Maggie using the Q&A or if you have additional questions you would like us to relay to Zach or Betsey, shoot them into the Q&A and we will forward them. I will keep talking until we get more questions for Maggie although I think that you have addressed everything that needed to be addressed in that presentation so thank you for that.

Maggie Sauer:

I would also say to the group here today, if you have tried to use the portal and it has not worked for you in the way that you thought. Or people's experience with other resources, the HRSA portal or other things, have not been helpful. It's really important for us to hear that too because we have not

heard anything in the next round of funding from Congress yet that would duplicate what we are talking about right now but you never know and it's really important for us to understand what works and what doesn't work as well. So I would invite that.

Hugh Tilson:
Thank you. We aren't getting additional questions. We will wind it down. Some quick reminders, there will be office hours on vaccines on Tuesday night 6 PM until 7 PM. You can go to the AHEC website for information about that and check with your professional societies and associations because they have great information and they provide real-time feedback for everybody on all of this. So if you need additional information, you can also always reach out to me. I am happy to provide whatever information I can about how to access this information. This will be on the AHEC website probably tomorrow, slides and recording. So you can follow up if you have additional information there. Dr. Tilson and Dr. Moore have agreed to continue these in the new year and we will send out specifics about when they will be but they will continue to be Fridays from 12:30 PM to 1:30 PM and it's not clear yet from their schedules whether the first and third or second and fourth will work better, but we will get that out ASAP. Thank you for all you are doing. There is light at the end of the tunnel. There's a lot of work to do but thank you for continuing that prevention work. We hope you will have happy, healthy, safe holidays. Take care. Goodbye.
[event concluded]