NARHC Webinar
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Covid-19 Testing and Testing Related Activities with CDC Experts

Bill Finerfrock:

0:02
OK, we're going to go ahead and get started.

0:06
Welcome everyone to the RHC Covid 19 Testing Technical Assistance Webinar. As you can see on your screen, this webinar is brought to you by the National Association of Rural Health Clinics and is supported by a co-operative agreement with the Federal Office of Rural Health Policy.

0:24
I am your moderator Bill Finerfrock, and our topic today, as I said, is already covered, 19 testing and testing related activities. We're pleased to have a group of people here from the Centers for Disease Control and Prevention, as well as the Federal Emergency Management Administration, our presenters today are doctor.

0:52
Second, President Crawford, Really community based testing sites, taskforce. They will each go through their presentations with regard to testing and testing related activities and their respective.

2:00
Can get a sense. Most are from in the country. A recording of the presentation will be posted on go see any RHC and the RHIB possible presentation. So I would like to recognize doctor Vicky Olsen.

2:31
Doctor Olsen, the floor is yours.

Dr. Victoria Olson:

2:34
Thank you so much, Bill. I want to thank you for this opportunity to discuss with you some of the policy options for sars.

2:41
cov are pertinent to action because of next slide, please.

2:54
So as you all are aware, there's been considerable effort focused on developing and deploying diagnostic assays for protection of sars probably to infection.

3:05
These tests are instrumental in identification and control disease appropriate that team within our nation.

3:11
Since the beginning of the epidemic in the United States late February until June first, there have been more than 70 million tests ports in the United States, and about 12% of those have been positive or the infection with the sars coby to virus.

3:32
The data that's shown here, reports from different states, commercial laboratories, as well as the CDC laboratories, primarily for the detection of the virus in samples for acute infection, And I'm going to discuss more in the next slides about the different types of diagnostic assays that are in use.

3:52
Next seconds.

3:57
So there are primarily two main types of diagnostic assays are those that detect the virus and those that detect the antibodies that are reacted to the virus, viral assays. Either detect the ... acid or viral antigen within the sample.

4:14
That's usually a protein that indicates current infection antibody tests however, look for the presence of antibodies that are produced by the person who is infected against the sars Kobi two virus.

4:29
This can indicate the person had a previous infection although it does not include somebody who has a current active infection.

4:37
Next slide, please.

4:45
There are a multitude of diagnostic tests that have been developed for detection of ... infection.

4:51
These viral tests have data on the sensitivity and specificity that have been submitted to recommend inspiration for use under the emergency use authorization.

5:01
These can be used during the pandemic for helping to identify those who are infected.

5:06
Several of these tests are commercially available.

5:09
The vast majority of the tests are focused on protecting the nucleic acid of the virus within a restaurant.

5:15
For example, from the patient, there is one test that detects the viral antigen or protein, patient sample.

5:23
We highly recommend that when you're choosing a test for diagnosis and ... infection, that you focus on those tests that have been reviewed by the FDA, and have shown to have a high specificity, ensuring that the positive results are accurate.

5:39

Viral tests also have different testing formats. There's those who are laboratory analyze, which often require a bit of a longer turnaround time before the results are returned, but usually have higher throughput.

5:52
There's also a point of care assays, which are much more rapid turnaround time, but have been shown to have some limitations on sensitivity. There are few that are currently noted to have negative results will consider presumptive and require confirmatory testing laboratory analyzed format.

6:11
Next slide please.

6:17
So there are several avenues available to attain viral test samples. Testing can be co-ordinated through your public health laboratories or contracted with commercial laboratories or in clinical labs.

6:28
When evaluating different options, the test performance should be reviewed. The data are publicly available on the FDA website.

6:36
Test has been approved EUA within the intended use document.

6:42
It also is important to ensure that whenever the tests will form the facility as well. Yes, yes, certified. In order to obtain results, that can influence here.

6:54
Next slide, please.

6:59
Now, all of these different diagnostic tests are still briskly dependent upon a proper specimen being collected and submitted.

7:07
There are several different types, of course, assessments that are acceptable with diagnostic tests.

7:13
Some of those are listed here, such as nasal pharyngeal, as admin, or orphaned through Assessment, selected by a healthcare professional.

7:20
As well, nasal swabs are sufficient for diagnosis gasses, as long as unit although induction of students currently not recommended for diagnostic testing.

7:30
This guidance on collection, handling and storing of patient samples is available on the CDC website.

7:38
Next slide, please.

7:45
When you are considering who should be tested, it is important to focus, first on those symptomatic.

7:51
Patients deplane symptoms, as well as healthcare facility workers, or other critical infrastructure workforce, such as those working in congregate living settings and first responders for the slain symptoms.

8:04
Um, also symptomatic individuals in congregate living settings such as long-term care facilities, prisons or shelters, other priority persons to task would be anyone. Anyone else displaying symptoms consistent with ... infection such as fever, cough, shortness of breath, chills, muscle pain. I knew a lot of taste or smell, vomiting, or diarrhea, and or a sore throat.

8:32
It also is appropriate to use the tests for asymptomatic individuals who are prioritized by health departments and clinicians such as those important for public health monitoring, sentinel surveillance, or screening according to state law.

8:46
Next slide, please.

8:51
What I just really focused on identifying those with acute infection, where the five of us now move on to the second general category with us, which is serology tests. Look for antibodies, the individual develops in response to the sars, fully to viral infection.

9:09
These antibodies generally develop 1 to 3 weeks after infection occurs, therefore the test indicates a likely infection in the pass napkins.

9:24
Firm that the person has a current infection, that relies upon a viral tests to confirm current infection, sars.

9:33
Within this aerobatic tests, there are two main types, those that look for antibodies, which react or bind to the sars virus and those that look at the ability to neutralize or prevent ...

9:44
virus from infected cells, serological assays are very valuable in understanding the transmission dynamics of the virus and thereby informing prevention strategies.

9:55
Currently, these tests are being used to connect with population Sarah prevalence Studies, but they are not recommended for use in diagnosing infection, which, again, requires that viral test.

10:07
Next slide, please.

10:12
As I just mentioned, the positive antibody test results indicate likely infection, but it's hard for me to at sometime in the past.

10:20

However, there is a possibility that the positive result might result for cross reaction antibodies against a non sars.

10:30
Will be Coronavirus screen.

10:33
The FDA website provides information on the specificity that has been demonstrated for the various tests have an EUA approval.

10:41
A negative test result does not include acute sars cov to infection, even though it cannot burn that you have an acute infection. The fact that you have antibodies does not mean that the infection as a result.

10:56
The antibodies develop anytime between 1 to 3 weeks after infection what is possible that somebody put in develop antibodies and still have a current infection.

11:05
If acute infection is suspected, viral testing is necessary to really determine whether that person has active infection with sars.

11:16
Antibody testing should not be used to diagnose or exclude sars cov into the next slide.

11:26
So as I mentioned, there's a lot of utility in that serology, serology assays. And CDC is using these in several different ways. We're conducting Sarah prevalence surveys to gather important information, such as, how much of the US population?

11:44
How is this changing over time?

11:47
What are the risk factors for the different, for the different characteristics associated with ... infection, and does that vary with age, location or underlying health conditions?

11:57
How many US residents had a mild or asymptomatic infection?

12:02
And that they didn't notice that they even had the virus. And finally, how long do antibodies against sars for me to remain in an individual act as a result the overnight to disease.

12:16
We are not using this era logic test to know how much of the US population is immune.

12:23
This obviously is a very important question, but they're just not enough information to understand what provides protection against future infection.

12:33

There are many researchers who are looking for ways to understand more about the virus and what can provide immunity or protection from overnight two, apparently we do not have sufficient information to really address that important.

12:48
Next slide, please.

12:54
So as of today there's currently 15 different antibody tests that have a FDA EUA approval.

13:02
And these are all listed on the FDA website.

13:06
The tests vary and how they determine whether antibodies are present some differentiate different types of classes at ..., differentiating IGG, IGM, others, totally antibody.

13:23
So far there is no data that seems to indicate an advantage of using one type of e-mail grab that one type of assay detecting a certain new globulin class versus another.

13:36
But the FDA, CDC, BARDA, and NCI are all collaborating to independently validate the different antibody and add that information or performance characteristics from available. This data is being added to the FDA website to truly help provide as much information as possible on the performance of these different assays.

14:01
As I alluded to previously, we still do not know enough about the virus and then what is the level of antibody response, which will provide immunity.

14:10
Nor do we understand how long that antibody response will remain after somebody results from disease. These are important questions that we are focused on understanding.

14:21
Next slide please.

14:27
So just recently, on May 23rd, the CDC added to our website. Some interim guidance that we've developed in collaboration with FDA on the use of serological assays.

14:40
Serological assays have many great attributes to provide valuable information in the investigation of transmission dynamics which can help inform prevention strategy, however they are not currently recommended for use in diagnosing acute infection.

14:57
Our knowledge and stars will be too rapidly evolving since it's such a new virus, and thus we are constantly updating our guidance documents as new information comes light.

15:08

Our current guidance on serological testing recommends the use of assays that have this FDA emergency use authorization. This indicates that they have provided information about the sensitivity and specificity of the assay to FDA for review.

15:26
Though the pandemic has spread nationwide, there is still a low prevalence of the virus within the majority of population.

15:34
In that type of situation, the risk of false positives increases dramatically.

15:39
The interim guidance that is on our website does define multiple methods to increase the positive predictive value of serological assays.

15:51
I will go over these items a little bit more on the subsequent slides.

15:55
But basically you should start with an assay that has high specificity, and that information can be found on the FDA website in their UA instructions for use.

16:09
You can also focus on testing individuals with a high probability, such as people who might be in an outbreak setting or an area where there has been a heightened.

16:23
Um, finally, there's also the option to do an orthogonal testing algorithm or you can increase your chances of positive result.

16:32
Truly representing somebody has antibodies against sars, coby too virus by using multiple serological tests.

16:41
Again I'll describe these a bit more on the next slide but basically the idea is to increase the prevalence of disease prevalence of antibodies within the population. So you have greater confidence in your results.

16:58
Until we understand more about the correlates to the protection and the durability and duration of immunity.

17:05
Antibody testing should not be used to determine an individual is detected.

17:11
OK.

17:12
Next slide.

17:17
So sometimes a bit of a confusing.

17:23
Situation is understanding predictive value.

17:28
So test performance, when you look at that. And you look at the sensitivity and specificity, those are characteristics of that specific apps.

17:38
However, when you look at the positive predictive value of a test, that is tightly related to the prevalence of the disease in the population, despite the characteristics of the test.

17:51
As well the negative predictive value, similarly tied to the prevalence of disease, and indicates the probability that subjects are truly negative, not have antibodies against sars.

18:03
Next slide.

18:08
So, even when you have a highly sensitive and specific assay, 95% sensitivity and specificity needs is assumed to only be 5%, which seems to be reasonable for a large proportion of our population.

18:26
Your positive predictive value is great implemented.

18:30
Calculations, currently would be about 50%.

18:34
That means I definitely want to focus on, are choosing an assay that has a high specificity, to help increase, as much as you can, the probability that the person having a positive test result has had a previous exposure or disease.

18:53
Next slide.

18:57
Now, there are ways that you can try to focus and increase your prevalence of disease.

19:04
You can try to focus on a population that you know is in a high setting an outbreak setting, or an area where there has been a considerable number of places.

19:15
In a way, increase the prevalence in that subset appellation.

19:21
In this scenario, the same assay, if you assume a chronic disease prevalence, has increased its positive predictive value to a greater than 2%.

19:31
And then that is using the same us, 95% sensitivity, 95% specificity acid.

19:39
Another method that you can use is the orthogonal algorithm, where you use your first assay, and you identify, even though it has a low hazard predictive value of, let's say, 50%. If you only look at those individuals who tested positive from that process, you are inherently increased prevalence and that subset of individuals.

20:03
And, thereby, the second assay, using a different target for detection of antibodies will have a much higher positive value.

20:13
And the FDA actually has a calculator available for determining positive predictive value based on different scenarios.

20:24
Next slide, please.

20:29
Now, moving to housing Loans for Quick Test.

20:32
The White House website provides guidance on, how you should understand the difference, test results. Whether it is a viral test, or sara logic, or antibody test.

20:43
And what that means, that positive or negative, and includes those who might have a positive viral test, a negative antibiotic.

20:53
You can see that the bottom there would be a scenario where you most likely currently do have an infection early enough that you have not mountain antibodies against the violence.

21:04
Alternatively, if you have a buyer negative test and antibody positive test, you most likely had ... disease and have recovered and have antibodies.

21:18
Our guidance does still reinforce that antibody testing should not be used to determine the new status individual for determining whole boarding or return to work until we better understand what is the core of many. What is the presence, durability, and the duration of immunity against this disease?

21:40
Next slide, please.

21:46
As I mentioned earlier, ... is a new virus and our knowledge is therefore be evolving.

21:52
They're constantly updating our guidance documents as we learn more about the virus and the disease.

21:59

We are trying to also expand the utility of different tests that we've developed to allow greater flexibility for laboratories.

22:07
We've been creating studies to evaluate different specimen types and collection method methods so that we can hopefully identify a sample type that's easier for pain and doesn't use some of the limited and valuable personal protective equipment that is needed by our healthcare workers.

22:25
FDA has also improved some at home watching and tests for self selected nasal swabs in saliva for certain diagnostic assays, the FDA EUA clearance.

22:38
At the CDC, we are continuing to evaluate different means of nucleic acid extraction methods. And technologies, this is in response to the fact that there have been some limitations in supply chain for certain regions that were used or our assets. So, we're trying to expand those with our current assay. And, therefore, provide more flexibility, and, hopefully, alleviate some of that's fine, too.

23:08
We're also, thinking forward, and looking at when the flu season will start again. ... is still circulating at the time of influenza, is. we know that there will be potential for co-infections as well. They both cause very similar clinical presentation. So we've developed at the CDC a multiplex assays that can simultaneously identify whether you're infected with influenza A, influenza B, or sars.

23:40
Beta on this assay is currently being compiled for submission to the Food and Drug Administration for another emergency use authorization.

23:49
And as I mentioned earlier, FDA, CDC, BARDA, and NCI are collaborating to independently validate the different antibody tests that have been developed and there can lead to be developed and refined, and we will be continuing to provide the performance characteristics of these assays and they will be updated on the website. Next slide, please.

24:18
I just want to leave you with some final thoughts. Some things to consider when developing sars tobii to testing plans.

24:25
Testing should always be conducted in consultation with the healthcare provider.

24:29
As well, it is important to confirm the testing facility is CLIA certified and utilizing an assay that as a FDA UA, positive test results, do need to be reported to the appropriate authorities.

24:45
And finally, regardless of the testing, use proper specimen collection and handling critical.

24:51
And that guidance is available on our website.

24:54
Um, thank you. And I believe we'll be holding questions after the next step.

Bill Finerfrock:

25:04
Yes. And at this point, I'm going to switch over to Sean.

Sean Crawford:

25:10
And, hopefully, can you hear me?

Bill Finerfrock:

Yes, we can hear you, and hopefully you can take control.

Sean Crawford:

25:22
OK, hopefully you can see my screen. We got it. All right, Great. Again, my name is Sean Crawford. I'm with the Federal Emergency Management Agency. I am the deputy on the community based Testing site Task Force, led by Rear Admiral Shorts with HHS. She's Deputy Surgeon General. We will go through a number of things, but I just wanted to say that our task force was established on March 15th. So we've been at it for a number of months now. And we've gone through iterative process of going through, first, one product program with the CTAS. And we have morphed into a C CTAS 2 0 program. And we've gone through a number of changes in our con ups that I'll go through, but I wanted to point these out as we go through this and make some recommendations for the rural testing and show you some examples of what Rural Testing Carlos might look like.

26:20
So, if the CBT S one program, what I've done here is just displayed the dashboard metric that we have in our system in order to attract all samples. But, we, as we originally started with 41 sites when we stood up, and I think are right around March 18th, is when we actually checked off the first testing. And we actually had a number of transitions of facilities that have gone to state managed or they've actually closed down. But, you can see with this initial CBT has one program.

26:51
The intent of this was really to focus on those health care professionals and those first responders to ensure that they could get tested outside of the hospital and clinic setting to ensure that they were ready and capable of still being and the kogod fight.

27:05
So, since, since March 18th, we have administered probably 237,000 tests, It goes up every day and review results at almost 230,000 tests with within the ... program.

27:22
And with the CBT S one program year, some visual representations of what those sort of look like, You've probably seen these on the news. And you'll see the that representation of all the cars and the drive up. The

heavy logistics footprint to not only administer the requisition information by collecting it at the cars, with all the, all the PPE on. And going through the various stages of the process, to, one, collect the requisition information, validate the driver or the passengers in the vehicle. And then, have health care professionals actually administer those tests to those individuals as they went through, primarily we. When we started out, excuse me, we were we were using the nasal pharyngeal swabs, as you can imagine, in a vehicle with passengers, et cetera, not necessarily the most pleasant experience.

28:15
I believe in the previous presentation, it was also alluded to that. In mid april, you have to date, FDA authorize the use of the nasal swab, and is an interior interior errors. And we went through the process of looking at, are caught up in revising our caught up to see how we could make our logistics footprint smaller and reduce the risk to those healthcare professionals that were working in administering those tests on those, on those vehicles on those passengers as they came through.

28:46
So with the with the revision of the ..., we're actually to significantly reduce that risk. Also significantly reduce the PPE reduction by over 90%. And why this is relevant is as you get into this sort of swabbing con up for the rural ..., you'll see that you won't require as much PV as you're out in your rural locations or in a mobile setting.

29:12
So, part of the process was, one, to get the information out there, and provide information to those folks that were actually considering testing as they were coming up to these locations. So we produced a, basically a flyer. And we also produced a video. And so the QR code you see here with the web link, that still is live. So, if you want to, go to that after, scan the QR Code or go to YouTube channel, and you'll actually see the process, step by step, or a powered passenger, would pull up to a location. And how the tests are administered, observed, et cetera. And how the folks within the vehicles can actually administer the test themselves. Put the swab in their nose, you know, with the guidance of the observer, and get a good sample, place it back in the vile. Sealed awhile.

30:02
And then, proceed to the next stage, where they will put the, the vital in the Internet, or into a ziplock bag, essentially, and, and then put it into a onto a containment or table, or something like that. Where it can be collected by the health care professionals.

30:22
OK, we also had to develop the step by step process for those implementing this process, It's a fairly Lean process, requires that pre arrival patient registration. As we got into, what I'll talk about in the two Concepts. Lot of states were actually administering this patient registration capability so they could do this ahead of time at the Telehealth platforms, etcetera. But they also can arrive on site where the requisition information still be gathered. And, the testing personnel have a, again, a much lower footprint when it comes to the number of individuals required to actually observe and, and manage this facility, but also the significant risk reduction in GTA. You saw the pictures before, but this will only require clothes and surgical mask at a six foot distance.

31:12
And as you get into Step three, the patient obtained as a kid. And then Step four, they administer the kit, as I just mentioned, are and administer the test and collect the sample. And then step five, the deposit, the sample at

a bank, and then drop it off. So, it can be QA QC by the Health Care Professionals on site. And entity is sent off to the labs, and then the patients are notified either by the laboratory portal or they're, they receive a callback for the call center that is designated for that site.

31:49
This, again, is a representation, but more individual fashion. And that step by step process, processing, individuals', either a walkthrough process or drive through process, and you can see the, the, the stages as they go through and the number of folks. So, again, significant reduction in the number of individuals with significant reduction in the risk to exposure.

32:16
one thing to mention is one when they get to station six, Essentially what we had a contract in place with the ... process, where we actually had FedEx pick up the samples after they were sitting in cold storage on site, sent off to a lab, and then processed. And then there was either a 1 to 5 day waiting period for individuals. But as we kind of get the two process, there's a number of point of care tests, and, and also the shipping, shipping off to labs. That's part of the process, as well.

32:50
So, as we got away from 2.1, we didn't leave one behind, because that's still remained in place. And a number of States wanted to continue with that capability that was very beneficial to their states. But we expanded with the ...

33:07
program, and this was a public, private partnership with a number of companies that can open the aperture to a number of locations that are already within their, within their facility capabilities, such as ..., Wal-Mart, Walgreens, et cetera, Those facilities could be used whether it's their parking lots. Are there drive-thru capabilities, things like that? So, we worked and partner with these companies and we were able to expand. And in a matter of a month and a half to about 438 sites and you can see that we've already doubled the number of samples resulted based on lighting the aperture and making a much broader for the American people to go and get tested at these locations.

33:55
Here's just a visual depiction of what the two concept looks like. You probably can recognize.

34:03
How this layout goes, if you've ever picked up? And let us another one of these types of facilities, but this is just one example of a drive through your capability where you pull up. You've already got your, you got your appointments, people. If you see the instructions, you get your test. You administer a test inside the car, you all and instructions to put it into the Valley and break it off. Or if it's small enough, it just fits in the Valley, seal it, put it in the bag and then deposited accordingly. And then you'll either receive the tests that day, the results that day, or if it's point of care, or you will possibly receive the results. the next 1 to 3 days.

34:48
So what was important about the two site, what is really helping our states and our communities meet the needs of where they were most underserved. And so, we utilize the CDC social vulnerability index. And what that really means is that it focuses on a number of factors, but primarily it looks at communities that are confronted by extreme stressors, such as the social economic status. Of those of those counties are the zip codes, the

household composition and disability, the minority status, and the housing types, all these factors were looked at when determining where to negotiate and put these CBT has two sites.

35:29
And, as I mentioned, there are 438 of them today.

35:33
Here are some recommended supplies that we utilize for our ... sites. The differences between 2.01, is we, FEMA and HHS don't actually supply the two sites that private partners actually handle that on their own. And with the two point, with a one sites, where we're had a number of federal and state individuals out there, we supply them logistically with supplies like this: Ignore the numbers, because that's not necessarily relevance based on your demand in your locations. But what we have here is just a series of supplies that were basically the essentials to have on hand to effectively manage a testable location. So, again, those numbers vary based on your demand and throughput, but these are things you can consider when trying to establish a rural health testing location.

36:30
So, some of the, the concepts with rural testing, obviously, it does increase a lot of flexibility for those states. You don't have to be a fixed location where you have to negotiate the spots, maybe even rent, the location, those sorts of things. But, that flexibility with a van or a bus or some sort of RV, you can actually go out and hit those locations that are most needed in those underserved areas. Your early target, those communities, or those industries that really need testing the most, want the flexibility and clean? It includes, you know, how you can rotate through your through your state, or your region, or your county, and the flexibility and the operating hours. That's, that's another benefit.

37:17
So, some of the other benefits with rural testing includes the reduction in the number of medical professionals that are necessary to establish a testing location with those rural locations. We've found that it's just a handful, maybe five or less depends on the communities they're serving.

37:39
And the co-ordination with the state makes it a lot easier because they can be established on state properties, county properties, things like that, reduces the need for heavy security, Securing the supplies and all those factors that weigh on having a fixed facility, It makes it a lot easier to manage the shipping of those specific supplies and stuff like that, so you can just pick up and then go out and do your route, and then drop off, et cetera.

38:09
Some of the other benefits, obviously is, maybe there's political desires to serve specific communities, or there are specific hotspots popping up, whether it's, you know, industry or certain select, underserved communities, et cetera. This allows you to hit those spots much quicker and and serve those areas that needed the most.

38:33
Here's an example of Alabama, where they stayed out of Montgomery. on a weekly basis, about a six day rotation. They rotate through three different cities, and this allows them to set their hours, went to arrive, where to stay, and willing to serve at a specific time. So they can work with those local townships. and have those sites advertized and know that they're coming on every Wednesday or every Thursday, et cetera, And continue to hit that until it's no longer needed, and adjust as needed as well.

39:07
Here's another example of Georgia, and we found that these are very successful when it comes to hitting those communities.

39:13
Again, you don't have to enter the facility footprint and be very mobile, and this is just a five day schedule.

39:25
Here's a visual representation of Dallas, Walkout Khan Concept of Operations.

39:31
What they've taken is just say it's a pre-fab, conics box that has windows and doors. And they've built a capability around it with a minimal logistics footprint on the outside. This can go on the back of a flatbed and can be fairly mobile. It's not as mobile as the, the van, and the IRBs, but it does allow to set it up within a day, and have an operational for as long as you need, and then move it as accordingly. So, again, it's a walk up capability.

39:59
Very similar to the processes I showed you before, but just another example of a mobile testing capability.

40:12
With that, I, I know we're going to have a number of questions after, but I'll wait to hear those questions. That concludes my brief. Thank you.

Bill Finerfrock:

40:22
Thanks, Sean.

40:23
And I will take back over and we'll quickly advance through at this point.

40:33
What we'd like to do is open it up for questions from the audience, and also, for those of you who are taking this for the CRA cheat, see our HCP certification. Your code is on the screen now.

40:51
While we are waiting and allowing people the opportunity to ask questions in the chat box, Kate, can you open up the chat box?

Cate Visser:

41:04
Yep, I did that. So, they should be able to start asking questions now.

Bill Finerfrock:

Can you read Box?

Nathan Baugh:

41:12
Ah, I cannot see. I think it's changing right now.

41:17
OK, I, can I see chat?

41:21
But I can go ahead and ask the first question.

Bill Finerfrock:

41:25
Kate, can you get the chat box open so that he can see it?

Cate Visser:

41:30
Yup, I'm working on that.

Nathan Baugh:

41:33
While while folks are typing in their questions, and we will get to those, the first question that I think that many rural health clinics have gotten, that I have is, do you all have guidance on who to test? and when to test?

41:50
Particularly in the context of a limited supply of testing.

41:54
Is there where, where can we find good policies on that?

42:02
Yes.

42:04
Go ahead.

Summer Galloway:

42:05
There's just, this is the summer galloway from CDC. I was just gonna.

42:08
I think that might be a good question for they thought that doctor Olson and and Sean Crawford.

Bill Finerfrock:

42:19
Doctor Olsen, you want to go first? Or Sean, whoever is ready.

Sean Crawford:

42:25
Sure.

42:26
We we actually use the CDC guidance for testing and I think that testing there's a link for that and I can probably put that into the chat window itself. But that's the guidance that we used originally was sent to the test healthcare workers that were asymptomatic. And then I think it changed over time and then we continue to it to utilize that CDC guidance for our testing parameters.

Bill Finerfrock:

42:53
I think doctor Olsen, you had something on that early in your slides as well from what was some of the early recommendations to where we've moved? But do you want to elaborate on that?

Dr. Victoria Olson:

43:04
Thank you very much. Actually, I do think that going to website is that we will get the most up to date, But, yes, obviously, we focus first on those symptomatic. But, there are situations where it's appropriate to test asymptomatic individuals as well. So, I believe that link that was shared will probably be the most up to date recommendations.

Bill Finerfrock:

43:29
And before we go on, doctor Galloway, I know there are a number of subject matter experts from the CDC who are also available to answer questions. You want to take a minute and have some of your colleagues introduce themselves?

Summer Galloway:

43:46
Yes. Thanks, Bill. And so, as Bill mentioned, we have a number of representatives on the call that have varying subject matter expertise. So I'm just going to run through those, I'll call on, on them, and they can introduce themselves and provide a little bit of information about their area of expertise. So, I'll start with doctor Ryan Fagan.

Bill Finerfrock:

44:14
Dr. Fagan even if you're available, and you can unmute,

Ryan Fagan:

Can you hear me?

Bill Finerfrock:

44:19
Yep, we can hear you.

Ryan Fagan:

Great.

44:22
Again, my name is Ryan Fagan.

44:24
I currently leading the healthcare infection prevention and control team, and the CDC response. I'm available to give you any information needed about the resources and state health departments, to support of current batch control activities, as well as where our guidance might be, including the federal guidance for healthcare personnel who are performing testing.

Summer Galloway:

44:52
OK, thanks, and then I'll turn it over to doctor Zanie LeRoy.

Dr Zanie LeRoy:

44:59
Hi, can you hear me?

45:00
Yep. Great. So I'm also on the Emergency Response at CDC. And I currently sit and the Health Systems co-ordination team, and also can provide some guidance in terms of healthcare facilities. And, more importantly, where to go on our website, because we have such kind of comprehensive information there.

45:21
Thank you.

Summer Galloway:

45:22
Thank you, and then I'll turn it over to doctor Christa Singleton.

Dr. Christa Singleton:

45:28
Hi, Good afternoon, I'm doctor Christa Singletons. I am currently, supporting the response from the Clinical Core Clinical Unit.

Summer Galloway:

45:39
OK, and then, doctor Heather Paulin.

Dr. Heather Paulin:

45:43
Hi, good afternoon, and I also sit on the Work Core Clinical Unit. We are a part of the larger clinical team that sits within the Health Systems Worker Safety Task Force, and we try to help answer questions on, you know, guidance related to clinical presentation and symptoms in therapeutics over.

Summer Galloway:

46:11
OK, thank you. And then finally, doctor Angela Starks.

Dr. Angela Starks:

46:17
Good afternoon, everyone. I'm also part of the response at CDC working on the Laboratory Task Force with doctor Olson and specifically focused on technical assistance to state health departments.

Bill Finerfrock:

46:31
Alright, Nathan, where you, are you able to see the questions coming in?

Nathan Baugh:

Yes, we have lots of questions coming in, so I'll just start at the top, and we'll get through as many of these as we can.

46:44
First question is from Marco Basquiat, he asks, what has been your experience or proposal for elevated temperature regions and rural sites?

46:58
I also believe he means the, in terms of the temperature that you could have in testing buildings. Like do you need AC and things like that?

Summer Galloway:

47:14
He, Yes, And, Sean, is that? Would that be shooting based on your?

Sean Crawford:

47:19
Yeah, So, typically, you know, during the Spring months, we weren't so concerned about that, but we did notice in Texas and a few locations. We were starting to experience issues with temperature and things like that, but primarily, what we're most concerned about besides the health of those people administering the test or those sitting in cars for hours, were the actual samples themselves. We process in place where we're actually refrigerating or samples on site. And making sure that they were shipped in these insulated uline containers

when the FedEx entities would show up and shipped as off. So, they had to maintain a certain temperature. And that was, that was very important, at least for the preservation of the sample.

48:03
But what we, what we were most concerned about was the healthcare professionals, and they're sitting in a car, so we definitely saw some impacts to processing and show individuals' and shutting down locations if it was too hot.

Nathan Baugh:

48:24
Alright. Great. Well, we'll go ahead and jump to the next question.

48:30
This is from Lisa Anderson. She asked, Well, she notes that they're following the CDC rules currently, especially in regards to folks that are asymptomatic, Asymptomatic, and are requesting testing. But she notes that there are limited on supplies currently, and she wants to know if, and when there will be a time, when they will be able to test without fumbling the CDC roles.

49:04
What would you, for example, what do you suggest when the supply is, such that, when it gets to a certain point or something on the supply, then you no longer need to follow the CDC rules?

Summer Galloway:

49:20
Yeah, So, I think once there's, if there are significant changes in the supply chain management, I think, you know, there may be, know, we, we continually review the situation, and update guidance as appropriate.

49:37
But, I think the standards right now, and are, or, you know, where, what folks should be thinking about, I don't know if anyone else on our team wants to add, to, to add anything to that.

Sean Crawford:

49:52
Well, this is Sean, and I can add a little bit if you'd like.

Summer Galloway:

49:55
Sure.

Sean Crawford:

49:57
So, based on the CDC guidance, does outline high priorities and priorities. So, if you look at the high priorities, it does focus on hospitalized patients, health care, facility workers, et cetera. But as you get into the priority after that, look at, it looks at individuals with symptoms, and then the last stage is persons without

symptoms. So when I mentioned or CBT has two sites, anybody can show up. And get a test, really doesn't limit those who can get tests or can't get to us. And I think CDC's outlined that pretty clearly.

Bill Finerfrock:

50:29
I appreciate that, because that was kind of my sense, as well shown, is that, you know, there's a priority. These are the people who, if whatever supplies you have, this is who should go first.

50:40
Once you have kind of addressed that group, then you can expand the class or groups of people and in many communities now, and it's just community wide testing, anybody who wants it, You don't have to be asymptomatic, they don't have to have been a healthcare worker. They don't have to. You know. So, what, what we're seeing, and I think what's trying to be encouraged his broad testing. But it's more of a priority of, these are the people, what whatever resources you have, you should try and do first, and then go from there.

Sean Crawford:

51:13
Yeah, that's correct. And I've provided the link in the chat, so it's actually provided to everybody, it does outline a trade clearly, and I think they'll get all the information on that topic, that location.

Nathan Baugh:

51:25
All right.

51:26
Great. Thanks. Next question. I think, I'll tee this up for Sean first, and then, if other folks want to chime in, they can.

51:34
This is from Kevin Rotunda, who asks, Are the self-swab test kits available for use now, and where can we attain obtain them from?

Sean Crawford:

51:46
So, I'll try to answer that, But I'm going to answer it from abroad FEMA perspective. There's been an allocation set for every state, and those allegations go out on a weekly basis. And I imagine they're sent out to a specific location that is administered by the state themselves, How you get those, how you get a an allocation from that state allocation. I can't necessarily give you that information in, because I just don't know, but I know that we're providing hundreds of thousands of swamps to states on a weekly basis. So they should be made available. There should be some sort of allocation you can you can acquire to to meet the rural needs.

Bill Finerfrock:

52:27
Is Shawn, is there a particular agency or office in state that you should contact with the Health department for the state or state version of FEMA?

Sean Crawford:

52:41
Yeah. So, the state version of FEMA's the State Emergency Management Agency. They'll certainly has some insights on how they're interfacing with FEMA on the distribution, but I imagine that the health departments at the state level would also have that information on where the allegations are coming, how to get an allocation from that state allocation.

53:04
I can probably look into that a little bit further, but I don't have any fidelity beyond that.

Bill Finerfrock:

53:08
Yeah, that's fine. But I think you know that there are things that folks can do Even. Just go online and look at your state health department or reach out, call them the other place. And we're going to be doing more in the upcoming weeks with your State Offices of Rural Health and this is something that we can look into with them. But in the interim too you may want to reach out to your state Office of Rural Health to see if they may have information as a point of contact as well.

Nathan Baugh:

53:36
Yes next question. Next question I think this one would probably be more directed towards CDC on this one is from Allison Jenson. She says, We have been looking for antibody testing through our reference lab.

53:53
The highest specificity test that is available to us is only 45% thoughts, suggestions.

Summer Galloway:

54:05
Doctor Olsen, do you want to take that one? You or Doctor Starks.

Dr. Victoria Olson:

54:10
Yeah. So this is Vicki Olson. I will start. Definitely. Dr. Starks can chime in for that.

54:17
Um, so I I guess I would have some concerns about using it.

54:24
Will pass that as they low specificity.

54:28
I think you said it was only 45% specific to that?

Nathan Baugh:

54:33
Correct.

Dr. Victoria Olson:

54:36
Again, this, this does go into the point about having a hello, general prevalence of disease. look at our nation, therefore, want to use the highest specificity tests that you can there are several logic or antibody tests that have FDA UAs and they are on the website.

55:01
I highly encourage people to review those. Look at the data that is available on them before choosing where you want to do that.

55:11
I would be concerned about moving forward with the tests with such low specificity.

55:20
I would consider local or elsewhere, I definitely think it's important to try to focus on those that have gone through the FDA process, I would have to double check, but I think all of those have at least 85% specificity, So, I'm assuming that this is an assay that has not gone through that process.

55:42
Those would be my thoughts.

Nathan Baugh:

55:46
OK, Thank you, Thank you, Victoria.

55:49
Then, next two questions: I'm going to actually combine there about rural health clinics needing to be certified under CLIA, and what they can do without CLIA certification, and are there tests that are CLIA waived, versus what do you need the CLIA certification to do, what components of testing do you need the certification for?

Summer Galloway:

56:23
Again, I would, I would defer that question to doctor Olsen or. Doctor Starks?

Dr. Victoria Olson:

56:29
Yes. So this is Vicki again and definitely Angela can Correct me.

56:36
Neither definitely you to utilize a laboratory that as school sort of want to test results, the impact patient care. Results are going to be returned to the withdrawal important, that that is part of the process.

56:55
There are moons where there is a waiver so that there can be some tests that are used in areas that are linked, but not necessarily direct facility. I'm not as familiar with the waiver process, I don't know if Angela is.

57:14
But it was important, that you utilize laboratory that has this CLIA certification.

57:20
And I guess I'd ask if Angela has any more to add to that.

Dr. Angela Starks:

57:25
Hi. No, I don't have anything additional to add, and we can certainly follow up that follow up on that question in terms of authorized testing locations, and how those may be linked with a with a CLIA compliant laboratory.

Bill Finerfrock:

57:38
I think part of this question, if I can interject, there are some vendors who are offering equipment, testing, actual testing equipment to for sale, to rural health clinics.

57:52
It would require reagents that they could have in their clinic to test the samples that they collect.

57:58
one of the genesis of the question is: she's currently operate under CLIA Waiver Status, as opposed to a lab with moderate complexity, or a lab of high complexity, and you may not be able to answer this. But if they were to purchase one of those pieces of equipment, to actually be able to do the testing in-house, as opposed to sending it out to a reference lab, would that require the RIT to obtain a lab of moderate complexity certification, as opposed to existing, as a physician office lab, which is under waiver? And one, if you can answer that, are you familiar with that? Those pieces of equipment? And one of the things that we've heard, is that, for some of that testing equipment, the reagents that are necessary to be able to do the tests, are in short supply.

58:53
And so the concern is the clinic's would potentially buy the equipment, Then find out the date. the reagents necessary are on a six month backwater, So the equipment would not be functional for at least six months.

59:08
Do you guys any insight on any of that or anything you can can add to that?

Dr. Victoria Olson:

59:16
This is Vickie. I don't have much, as far as insights into the waiver process, What is allowed, and what is not about, as far as the testing.

59:25
I know that there is the river crosses the place in some, testing it, But I would really defer to CMS to really answer, what is allowed and what's not allowed.

Bill Finerfrock:

59:41
I think that's going to be a CMS FDA question.

Dr. Victoria Olson:

59:45
Yes. And again, not knowing the exact equipment that's being referred to, I don't think I can speak a lot to that as well.

59:54
I know that there are some point of care tests that have demonstrate some limitations as far as producing false negatives.

1:00:05
There was an FDA announcement that for one of those that need to start considering the negative, as a presumption that needed to be confirmed with a different assay.

1:00:20
But other than that, I speak to that.

Nathan Baugh:

1:00:26
So our next question is actually pretty, pretty much on that topic and it's directed to you, doctor Olsen, is from Kelly Dickenson. She says that rural facilities use point of care test to determine if they need to use PPE when caring for patients. If they have a negative results, do they still have to wait for the state lab results?

1:00:49
I'm and I think you just alluded to that.

1:00:53
But do you have any advice in this scenario? Should they, how should they treat the patient if they have a negative point of care result?

Dr. Victoria Olson:

1:01:05
So I think it's going to depend on which assay they're using. I will definitely recommend looking at the FDA website to understand how to interpret the results of that as well.

1:01:20
The recommendations by the FDA are very specific to a certain platforms. So I think that it would depend on what assays are using.

1:01:31
Hmm.

1:01:32
So unfortunately, I can't.

Nathan Baugh:

1:01:36
Thank you, Doctor Olsen. Next question is from Lisa Anderson as perhaps this is for Sean. She says, We have issues getting supplies such as test kits, PPE, and gloves looking for suggestions on how and where to get supplies.

1:01:51
Do you have any starting points?

Sean Crawford:

1:01:59
What HHS and are providing the states is swabs and media.

Bill Finerfrock:

1:02:07
Yeah, I think you answered earlier. Sean is that's probably something that questions are best directed to the state.

Sean Crawford:

1:02:19
The same, you can request assistance through the State EMA.

Nathan Baugh:

1:02:25

So, that was the State EMA. Is that what you said?

Sean Crawford:

1:02:31
They can request support when they have deficits in PPE, whether it's the gloves.

Bill Finerfrock

1:02:49
Yes. You're fading in and out there, Sean.

Nathan Baugh:

1:03:02
Maybe we'll circle back on that, Sean, and go ahead and move on to the next question, which is from Patricia Brooks. And she asked with the possibility of schools opening in the fall. Would you suggest that we tried to work with the education sector of the community to test all staff and school employees, staff, maintenance, cafeteria workers, et cetera. How would you would you suggest looking into those kinds of mass testing? And what does that testing look like? Is that viral? Is that antibody or is that some other sort of testing that you think would be best app for for when schools re-open?

Summer Galloway:

1:03:50
So I think, let me turn it over to doctor Heather Paulin, and I think she could provide an update on on this.

Dr. Heather Paulin:

1:03:58
Hi, I'm from the clinical team. So, testing is not our primary lane, but I just wanted to say that.

1:04:08
I know another team is working on guidance and currently updating it for and institutional educational settings to consider and how to direct testing for contacts of ... positive cases. And it well addressed and what to do if they're symptomatic or asymptomatic. So further guidance in this arena should be forth coming soon.

Bill Finerfrock:

1:04:44
Is there a list or a someplace where folks can sign up that as information is updated as it becomes available, they would automatically get those updates, or is it for a situation of, they just need to periodically visit the CDC website and seek out any updates?

Summer Galloway:

1:05:08
Hi, Bill. So, what we can do, so, you can certainly sign up. So, CDC does send newsletters. I don't think that you could count on getting an e-mail every time guidance is updated. But what we can do as we can add you to our we have a broader distro distribution list, where we send, when we've updated guidance, and we'll send announcements and things like that. So, I can add you to that distribution list. And then maybe that's something that you could circulate with your membership. Yeah, that would be great. That would be wonderful. We'll be happy to do that. So, yeah, if you send us updates, we're happy to forward them on to our community.

Bill Finerfrock:

1:05:46
OK, great, I'll, I'll take that.

Nathan Baugh:

1:05:51
Excellent. All right, So the next question is from Madison Harman.

1:05:56
She wants to know about employees of the clinic or healthcare workers themselves.

1:06:03
She says, employees who test positive, do they need to be retested before, returning to work? And, specifically, she wants to know how often do nursing home staff who are caring for Cove in 19 positive patients and are asymptomatic need to be tested?

Summer Galloway:

1:06:25
And Doctor Fagan, are you able to provide some perspective on that?

Ryan Fagan:

1:06:31
Yes.

1:06:32
Getting unmuted so in terms of starting with the scenario of a health care worker, who has tested positive, we do actually have specific guidance on that. and it does not require testing before returning to work.

1:06:49
We have both symptom based and test based strategies for return to work. Rather than the quote those, a night, somebody could collect links of the guidance. As I understand, there's a ton of guides on our webpage and it's hard to define. But a lot of these questions are answered prepare.

1:07:05
Now, encourage people to look at those two Strategies for return to work, to be familiar with either option in terms of the question about frequency of testing in nursing homes. And actually, some CMS requirements now that are starting to come out of that many states are doing at least a one time. what's called a prevalence survey, everybody in facility, patients, and healthcare personnel alike. I don't believe that there is a requirement beyond doing that at least once.

1:07:36
Although, you know, I would highlight that there's the testing for healthcare personnel is really part of a strategy that includes, you know, reporting unprotected exposures and staying home sick. In addition, the consult and screening for Tepper symptom checks on entry to facilities, and so there's more to it than just the testing.

1:08:01
And I'll, I'll add to this, that the testing supply situation has gradually been improving for hospitals and long-term care facility bodies. I think it's better to point out that they've also been prioritized and some of these efforts, and so I think those of you that are asking these questions about life supplies, as well as the supplies, please make those requests known to the appropriate state health authorities who have probably been hearing a lot more possible, long-term care facilities. It will be helpful for them to know that there is this need and demand coming from rural health clinics and similar settings well, over.

Nathan Baugh:

1:08:43
Great.

1:08:47
All right. I'm, I'm seeing a bunch of questions, that I am skipping over just for the audience to know, either they're repeat question, are there questions about the money that rural health clinics receive that the folks at CDC Or FEMA are not able to answer.

1:09:06
So, that's just wanted to put that out there as to potentially why your question might have been skipped over.

1:09:17
Um, the next question I have is from Tsuda Mahajan, who asked, Regarding pediatric testing, the testing done at the health department in some counties in Alabama is taking 7 to 10 days. Some of the local testing centers are only testing adults. Any options for getting pediatric patients tested with a reasonably quick turnaround time.

1:09:42
So, does that does the disparity between tests for children versus the test test for adults? That makes sense, and what's going on there? Does anyone want to speak to that?

Summer Galloway:

1:10:00
I think this might be something that we have to take back because I'm not aware of the Disparities Center.

1:10:11
So I think I think we could take that question back and follow up via e-mail.

Bill Finerfrock:

1:10:18
I had a question and I think there's some aspect of some other things, but some states are, are advising certain quarantining of individuals who've been exposed or thought to be exposed to, someone with covert if that individual gets a test, and the test comes back negative.

1:10:41
Should they continue to need to be quarantined? Or is having a test result that's negative Be sufficient to say you no longer need to be quarantined.

Dr. Heather Paulin:

1:10:56
Hi, this is Heather Paulin and I can comment on that, and so the incubation period or the potential incubation period or risk period is not over a negative test does not cancel the at risk period.

1:11:13
So, theoretically like if I had a negative test, you know, seven days, you know, after my at my exposure and I was, you know, I was then kind of midway through I think my potential incubation period.

1:11:28
My tested could theoretically become, you know, turn positive, you know, a few days later, even if I was asymptomatic or symptomatic.

1:11:38
So it does not end or terminate at risk period. Does that make sense?

Bill Finerfrock:

Yeah, that was because the, I think, the theory as well, and you either have the virus or you don't. and, you know, the test is administered, That's determining whether or not you have the ... virus, the, the ... was to determine, you know, that. So if you had to test, what you're saying is, though, you could get a negative day three post exposure. It doesn't mean that you don't have the virus because it may not actually manifest itself, A brave be sufficient to show up on a test until a few days later

Dr. Heather Paulin:

Exactly.

Bill Finerfrock:

OK, yeah.

1:12:23
Nathan.

Nathan Baugh:

We're actually at the end of our chat questions in the chat.

1:12:29
There are a few questions, again, that are not relevant. Walk, there was a question about vaccine, which I don't think we are able to answer yet because there is no vaccine yet. So, we're at the end of the line in terms of questions in the chat box. Bill, do you have any questions that you might just want to ask for the cause?

Bill Finerfrock:

1:12:55
Well, not ask. I did want to let folks know, there has been some question as to whether or not the viral test or the antibody test. Both would qualify under the monies that were made available for RHCS or testing and testing related activities. And if you engaged, either one is permissible for coverage by the dollar two received, if you want to use that money for viral sample collection or antibody sample collection. Either one is fine and official guidance on that should be forthcoming, but, we have received information indicating that either one would be permissible for use for the Covid 19 that you received a couple of weeks ago.

Nathan Baugh:

1:13:46
Great. And I have a question.

1:13:48
I guess I've seen in the news that some factories and, or companies, when they are having their employers return to the factory, or the office or whatever, are requiring their employees, do a temperature check where they just, you know, see if they have a fever. Is that kind of thing useful? What, what it is that recommended? Should rural health clinics be helping employers in that area do that sort of activity as we return and re-open factories and whatnot.

Summer Galloway:

1:14:32
So that I think, would be a good question for our, our worker safety team. I can take that back to them. We don't have a representative from that group on the call. So I'd be happy to take that back to them and then follow up via e-mail.

Nathan Baugh:

1:14:48
OK, thank you.

Summer Galloway:

1:14:50
Absolutely.

Bill Finerfrock:

From any of our either the CDC or Representative Shawn or Doctor Olsen, any final comments or anything that you're thinking? Gee, I neglected to amplify or mention this if you'd like to, share with our audience.

Dr. Victoria Olson:

1:15:15
This is Vicki Olson

1:15:16
I can't think of anything that I forgot to mention, but I'm sure there are some things definitely appreciate that the work, direct those questions to ask somebody to find you the proper guidance.

Summer Galloway

1:15:35
Yeah. And just to follow on what Vicky just said, if you if, if if there are questions, I can send you an e-mail address where you can direct those to so that we can make sure that they get to the right person and we can get a response back to two folks.

Bill Finerfrock:

1:15:54
Great. Thank you. And, Sean, any last comments?

Sean Crawford:

1:16:01
I certainly want to thank everybody again, if I didn't answer your questions, clearly or you have additional questions when it comes to testing and test sites, we can certainly get those answered within our task force. Or reach out to the other task forces here, get the answers for it.

NARHC Webinar
Tuesday May 26th, 2020
Bill Finerfrock, Nathan Baugh,
CDC Staff: Summer Galloway, Scott Miller,
Victoria Olson, Dr. Zanie Leroy, Dr. Christa Singleton,
Dr. Heather Paulin, Ryan Fagan, Angela Starks, Diane Hall
FEMA Staff: Sean Crawford
HRSA Staff: Kerri Cornejo

Bill Finerfrock:

1:16:18
Great. Thank you. Thank you. And on behalf of the National Association of Rural Health Clinics and the Federal Office of Rural Health Policy. I want to thank our new friends from the CDC and FEMA for participating in today's webinar, and in particular, Doctor Victoria Olson and Shawn Crawford for their presentations. Please encourage others who may be interested to register for the webinar series. They can go to www.narhc.org or the Rural Health Information site, and sign up. As you know, there are no charges for participating in these webinars, and we will be conducting several more over the coming weeks on topics of general interest to RHCS as well as more with respect to Covid and Covid 19.

1:17:11
Again, for a certified rural health clinic professionals, the CEU's on the screen, YGK761. We will put out information on our next webinar as soon as it gets scheduled. Again, thank you, everyone, for your time today, and we look forward to talking to you again in the future.

1:17:29
This concludes today's webinar.