

ASPR Health Care Readiness Cooperative Agreements All-Recipients Webinar

May 11, 2022

Call Transcript

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Jennifer Hannah: Good afternoon. Thank you for joining the ASPR Health Care Readiness Cooperative Agreements All-Recipient call. I am Jennifer Hannah, the Deputy Director of ASPR's National Health Care Preparedness Programs or http branch and to begin today's call, I would like to provide a brief overview of our agenda. Next slide please. First, I will provide a few ASPR Health Care Readiness Program updates. Then I will pass it along to the team from ASPR TRACIE to provide us with a few updates on recently published resources. Dr Richard Hunt, the Senior Medical Advisor for the ASPR NHPP Branch, will present the ASPR Health Care Readiness Capabilities update. Finally, we will conclude today with a general discussion and closing remarks. Next slide please. I'm excited to announce ASPR has officially completed the website transition from PHE.gov to aspr.hhs.gov. The new website showcases ASPR's mission and priorities along with innovative approaches to fight COVID-19 and information on health care readiness response operations and medical countermeasures budget and funding. A member of our team will share the direct link to the homepage and to the health care readiness webpage in the chat. Next, I'd like to announce the HPP recipient fact sheets for 2021 are available. The fact sheets include key programmatic information such as funding levels, spotlights on preparedness and response activities and COVID-19 response highlights for each of the 62 HPP annual cooperative agreement recipients. A member of our team will drop a link to the website with the 62 fact sheets, for your future reference. Next slide please. Stories from the Field provide the opportunity to highlight the hard work and accomplishments of our health care readiness cooperative agreement recipients and sub recipients. We have recently posted four new stories, highlighting efforts in Illinois, New York state, American Samoa and Maine. The stories provide an example of the diversity of support that ASPR funding offers recipients and sub recipients as a bolster to emergency preparedness and response. To read these stories and more head to the aspr.hhs.gov website. A member of our team will drop the link in the chat. Next slide. Over the last 20 years HPP has worked with our partners to improve patient outcomes during emergencies, face health care system recovery, and enhance health care systems resilience to be prepared to face future challenges. Throughout 2022, we will spotlight HPP accomplishments in the health care readiness bulletin and on social media as part of our #20 years of HPP campaign. We invite you to follow the hashtag. This concludes the program announcements for today. I will now pass it along to ASPR TRACIE for the next session.

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Audrey Mazurek: Thank you, Jennifer. Good afternoon, everyone. My name is Audrey Mazurek and I am the ASPR TRACIE program director. On behalf of our director, Shane Brannman, and the entire ASPR TRACIE team thank you for the work you do to keep our community safe and healthy and for continuing to be great supporters of ASPR TRACIE. As a reminder, you can visit our website and view our health care preparedness resources at asprtracie.hhs.gov or call us to request technical assistance at 1-844-587-2243 Monday through Friday 9 to 5 EST. Next slide. Here are the new resources from ASPR TRACIE since our last update in February. I have a few resources I'd like to specifically point out. First, our Climate Change Resilience and Health Care System considerations document provides considerations for

health care executives and emergency managers who are planning for the impacts of climate change. Second, we also conducted an accompanying webinar with the HHS Office of the Assistant Secretary for Health, the HHS Office of Climate Change and Health Equity, and the Blue Cross Blue Shield of Massachusetts about patient health and patient surge on their health systems resilience. Please check out the linked webinar and document in the presentation slides. Third, in spring 2022, ASPR conducted a review of open-source materials to determine the Crisis Standards of Care actions taken by each state during the COVID-19 pandemic, which many of you have already received that email from us. We also have a summary document that provides the key findings from that review and the recent literature, including challenges and suggestions for future work to help ensure a more equitable and uniform response in the future. Additionally, ASPR TRACIE quickly developed a Countries Experiencing Conflict webpage per request from leadership to assist with partners providing support to the war in Ukraine. We also have responded to many select TAs, and you'll see all the select TAs that we have redacted and posted on our site. You can see what your colleagues and peers have requested from ASPR TRACIE over the years. Most recently, we have a few TAs around cyber security and the role of rehabilitation professionals in disaster preparedness response. With our SMEs, we recently created a job action sheet for a health equity diversion and inclusion role under the Incident Command System. We also updated quite a few of our topic collections, including our workplace violence collection. I want to point out that we recently recorded webinars on workplace violence, excess mortality, and COVID-19 surges. About a week and a half ago, we conducted a speaker series recording with WRAPEM, one of ASPR's Pediatric Disaster Centers for Excellence, on their use of the ASPR TRACIE pediatric surge annex template and the accompanying toolkit. I want to plug the summary of tools and templates for health care coalitions, which includes a full list of the templates and the recordings you may find helpful as you fulfill the HPP FOA requirements for the specialty surge annexes. We've also covered some targeted topics in our speaker series including blood supply issues and the impact of COVID-19 on solid organ donation and transplantation. There are a few resources to keep an eye out for over the next couple of months from ASPR TRACIE. I'd like to highlight our Disaster Available Supplies and Hospitals or DASH tool, which we're currently developing in collaboration with healthcare ready, RDHRS 7, HAIDA, CIP, NHPP, and many other subject matter experts. DASH is an interactive tool that can help hospital emergency planners and supply chain staff estimate supplies they may need to be immediately available during various mass casualty incidents and infectious disease emergencies based on a number of hospital characteristics. DASH is comprised of several modules, which will be rolling out over the next few months. All the modules together can give a holistic view of the supplies needed to address incidents. The modules are pharmacy, PPE, burn, and trauma. I also want to point out the *Exchange Issue 15* will be available later this month. The focus is on health care ethics, crisis standards of care and will also highlight our key findings and lessons learned that we collected from jurisdictions that utilize a Medical Operations Coordination Center or a similar patient load balancing effort during COVID-19. We're also going to look at the role of military and how their assets played a supporting role during the pandemic response. We have a few upcoming presentations, ranging from the impact of COVID-19 on the delivery of oral health care to looking at innovative hospital designs through the lens of recently opened hospitals and the patient care elements they included in those design elements. We're also going to be featuring several health care coalitions as they share some of their recent lessons learned, specifically around fit testing, behavioral mental health and creating a regional dashboard to monitor the COVID-19 pandemic. With that, I'll turn it back over to Jennifer.

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Jennifer Hannah: Thank you, Audrey. I will turn it over to Dr. Richard Hunt, the senior medical advisor within ASPR NHPP branch to provide an overview and an update regarding the ASPR Health Care Preparedness and Response Capabilities document.

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Richard Hunt: Thanks, Jennifer. Today I'm going to be leading the discussion and update on ASPR's Health Care Preparedness and Response Capabilities document. As you're aware, we're in the process of updating the document. It has been the point of reference for health care facilities and health care system preparedness for the past five years. The goals today will be to describe the vision for the updated Capabilities, articulating the Capabilities that healthcare organizations need to save lives and continue to function, during and after disasters, review the preliminary list of topics considered for inclusion in the updated healthcare preparedness and response Capabilities, and get feedback on the preliminary list of topics and other topics that should be considered for inclusion through a discussion and a follow up offline review. We realize time is limited and there are a lot of people on this call, so we're going to try to pack in as much as we can in the next 25 minutes or so, but there will be an opportunity afterwards to provide the input in writing. The objective of the new Capabilities is to focus on Capabilities that healthcare delivery organizations need to save lives and to continue to function, during and after disasters. The intended audience is the nation's health care delivery system, as well as those who support that health care delivery system during a disaster. The update will address challenges and developments in healthcare preparedness and response efforts, since 2006 to 2017 including the pandemic, but also non-pandemic-related disasters. It's not like we haven't had other disasters in the middle of a pandemic. The Capabilities will provide an all-hazards, all-threats approach that provide Capabilities needed to respond to many types of emergencies. We will reflect on the perspective of healthcare leaders and partners as well as frontline healthcare providers and workers, so that all entities within healthcare preparedness and response functions can see themselves in the Capabilities. The update will incorporate equity in preparedness and response functions to ensure that the needs of at-risk individuals are addressed as well. In addition to revising the content of the Capabilities we also aim to improve the usability of the document to best meet the needs of the field. For example, a three-volume set at 100 pages, is probably not that going to serve us well, so it will be much shorter than that. To reflect the vision of the future Capabilities, you see the new document has several overarching topic domains corresponding to a sub-focus area. Based on the research we've done so far as well as the internal stakeholder discussions we've had, we see eight overarching topics that include incident management, response data coordination, information sharing, patient distribution, hospital surge capability, which includes both no notice surge and long-term surge, additional response needs, and planning and awareness of the legal and regulatory environment in which we function. As you read through the slides, please note any questions you might have or use the chat function directly to share your responses and comments. Again, with so many people on, it's going to be difficult to get a lot of verbal feedback, but certainly use the chat function. As you can see the eight domains can further be broken down by the focus areas they include. The encompassed topics underneath each domain are shown here. We'd like to note that the proposed list is not intended to reflect the structure of the document, but rather to convey the list of eight overarching topic that will shape the next iteration of the Capabilities. I'll also add that the topic list is subject to change based on feedback. Some of that feedback we've already received and really look forward to the feedback there, but also to the future feedback from all of you during our discussion today and through future stakeholder engagement

sessions we have. Additionally, health care coalitions, the Regional Disaster Health Response System components of the National Special Pathogen System components, and other initiatives that ASPR supports will also be addressed as components for achieving and supporting the Capabilities in the updated document. I'm going to pause here for a second to allow you to look and reflect on the proposed domains and sub-focus areas shown on the screen. There's a lot of information there, but focusing on those topic areas is really helpful. Before we move to the next slide, we do have a few discussion questions. I want to make sure there's an opportunity for you to comment in the chat or verbally about the critical things we've either missed or we need to add or if we have things that aren't worthy to include. Let's do the next slide. You can bookmark the Capabilities page on aspr.hhs.gov. To submit a written question or respond to a discussion question, select the chat icon. To ask a question or respond to a discussion question verbally, select the participants icon and raise the hand icon. I'm just going to read through these questions, so you can have the opportunity to respond in the chat or use the function to raise your hand. For the first question, what are your thoughts about the proposed list of topics? Are there topics that save lives that are missing on our list today? Are there topics that we should remove? Are there topics you would prioritize? Are there topics you would build out further? From your experience with the pandemic and other events, are there that strike you as needing to spend a lot of time and energy? If so, how would you build that further out? Also, among those topics, where have you seen challenges with addressing the needs of at-risk individuals and inequities in health outcomes? What resources have you've found helpful in your preparedness and response through the pandemic and other disasters? Yesterday we had a session with the EMS community. They had a specific resource that they are working on right now that may be helpful to us, so please think about those kinds of resources as well. When it comes down to the core capabilities that we need, certainly, we need to continue to have the capability and capacity to continue to deliver care during a disaster. We've seen during the pandemic and other disasters where hospital's suddenly have had to either close or be evacuated. What's contributed to your capability and capacity to continue to deliver care? I think not of just healthcare facilities, but also healthcare delivery systems, certainly being inclusive of the out of hospital environment. And then what do you see as your unique role in supporting the achievement of these capabilities that we're developing? What topics are most important to you and your organization's readiness to respond to disasters? There are a lot of questions there. More than anything, what we want to do want in this presentation is make sure you see where we are with it and have the opportunity to respond. I see the question about patient distribution. In terms of patient distribution during the pandemic one of the things that we have discovered through actual evidence through a study done by NIH is hospitals that have surges of patients, potentially, one in four died because of the surge itself, because that facility was unable to meet the needs of the patient. That is a lot and is a considerably important finding. To minimize that it comes down to load balancing and distributing patients across the healthcare delivery system, so no one institution is surged to where they are unable to meet the needs of patients. That's what we mean by patient distribution, and it connects very closely to the concept of load balancing and the concepts of medical operations coordination centers (MOCCs), which then support load balancing and patient distribution across, so hopefully that helps.

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Odessa Magafas: We have another question about the response data coordination and what it will look like.

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Richard Hunt: Let's move back to the slide with the subtopics. Here are the subtopics that include objective data, subjective data, and then it's real time or near real time data with a focus on, not week-old data, but just in time data. Additional data needs might be required to support federal, state, or local responses, and then coordination amongst all those. That's the big picture of where we're at with it right now. If you have specific comments on how to do that best that's what we're looking for today.

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Odessa Magafas: We also had a comment about how patient distribution and the use of MOCCs make some sense. However, in rural and frontier states where hospitals are hundreds of miles apart distribution in MOCCs are less important or less likely to be needed or used.

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Richard Hunt: That's a great question. We have a meeting immediately following this with rural and frontier health care coalitions. Your point is well taken. How does the rural and frontier health care contribute when it comes to load balancing? It's a two-way street, which was recognized during the EMS call yesterday. Rural and frontier health care facilities need to transfer patients hundreds of miles away and we recognize and appreciate that need. About 10 years of my career was figuring out how to do that. In terms of that transfer Capability, it's got to involve both a medical long-range transport and an accepting facility. One of the points made on the call yesterday, by some of your colleagues in the EMS arena, was the contribution of multiple health care facilities to load balance, in a way that, for example, they all can't go to a tertiary care center. We have to spread it out. The concept of back transfer or going to areas that don't have a surge of patients, which may involve rural and frontier areas. It's a two-way street. Anyway, I'm giving you some thoughts on the engagement of rural and frontier. That's not the way it's going to end up, necessarily, in the Capabilities. I see a follow up question about load balancing and patient distribution, if that will be an HCC function or if HCC will support that function at the hospital level. In terms of load balancing and patient distribution, on the call yesterday, there was an appreciation that it was everyone's responsibility and it needed to cross state lines and local lines. Certainly, at what level HCCs will need to be engaged that's not totally clear at least at this point. Certainly, there is an understanding it needs to cross jurisdictional breakdowns.

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Odessa Magafas: There was another question about patient distribution. Specifically, about clarifying what the measures and goals are, if it is more about having a plan, how to activate it, or if it is meant to establish and maintain an actual MOCC.

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Richard Hunt: I don't have the answer to what's going to show up in these Capabilities, but attendees may put in the chat what they think will be the most supportive in distributing patients across health care, so no one institution is surged such that it compromises care. Much of the energy right now is around patient distribution, load balancing, and the real-life realization that we have evidence that decreasing surge is no longer a luxury. It's lifesaving. Patient distribution to prevent surge is lifesaving. Therefore, how do we, in health care delivery, get our arms around that, in a way that we can load balance. That's the bottom line - how to load balance patient distribution. Reflecting some of the comments in the chat about the best way to do it. It seems there's a couple principles that have come to

light. Based on the MOCCs that have been stood up, a number of them were successful at patient distribution until the healthcare system is so saturated that nobody accepts anybody then collaboration breaks down. Therefore, how do we get our arms around that, especially in that kind of circumstance, which happened to be the last wave during the last week of the pandemic. We need to identify how we can be more effective in that and there are a lot of ways of doing it. We all need to figure this out. There are many drugs that are reported to be lifesaving, but think about the clinical operations, if we get the load balancing right. One in four die at surged hospitals potentially because of the surge itself. We have a huge opportunity to save lives that we didn't know about until the pandemic and the science that NIH did to describe that.

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Odessa Magafas: We have another question about the potential for different priorities, state by state, and how to incorporate that into the Capabilities.

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Richard Hunt: I'm going to read into the question like threat analysis and hazard vulnerability analysis to down to that state level. At this juncture, I don't see it as having an overarching state document then 50 chapters state by state along with territories. I certainly see if these are national health care preparedness and response capabilities for the nation, not just ability, but I would be hopeful they would be utilized by states from which to pivot from and do deep dives at a state level, local level or coalition level, an RDHRS level, a pediatric center of excellence level, and so on. I see it much more as an overarching document with the ability to build on that to have chapters that states develop or local entities develop. It would be helpful to group surge strategies together to include decompression distribution, internal capacity development, and medical transport, for example. As a reminder, these are just topics and thinking about how to organize this. We haven't put up an organizational structure yet. We want to make sure the topics are going to be helpful in saving lives and supporting a health care delivery system to continue to function during disasters. At this stage, we want to make sure we've got those big topics set. We're looking to build those out with things that are most important from your experiences.

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Odessa Magafas: We have another comment that reads, this year it worked very well when the HPP Capabilities were aligned with the PHEP Capabilities. It made it much easier to exercise and plan across programs when they matched up. When HPP went with the four Capabilities, it made it more difficult to plan and train an exercise in conjunction with PHEP partners. I'm not sure having a different set of Capabilities for HPP is the best solution.

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Richard Hunt: I'll take that comment under advisement and note the purpose of these Capabilities are for health care preparedness and response health care delivery, which certainly is complimentary to public health, and vice versa, so we recognize that.

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Odessa Magafas: We have another question here about if there will be a crosswalk once the Capabilities are finalized.

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Richard Hunt: We're not there yet. I see a comment about the possibility of having two sets of Capabilities, one for high population or urban/suburban health care systems and one for rural frontier health care regions. That's a comment we will take into consideration. Again, we have just started engagement. These are the topics we're thinking about. We haven't rolled out the Capabilities by a long shot. We're just beginning with that. During the EMS call yesterday, I asked specifically how EMS leaders were leaning in their preference about being integrated amongst the topics considered or standalone. Because they're part of health care delivery, but they're a little bit different out of the hospital, they said they were unanimous and think they need to be integrated. My initial thought about that is assuring the timeline about the rural frontier, if they are standalone or integrated because of the codependence. I mean they really are dependent on each other. The urban/suburban being dependent on the rural frontier and vice versa. My lean right now would be to integrate and make sure the needs of a rural hospital is as much reflected as the needs of a critical access frontier hospital. That's at least my initial thought that and I'm happy to hear contrary to that.

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Odessa Magafas: We have a comment that agreed with the earlier comment about PHEP Capabilities alignment. We also have another question that asks if ASPR will establish revised response data coordination, EEs, with this Capability.

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Richard Hunt: That has been a challenge for decades. I don't see the Capabilities documents solving that. I think it can point the way towards some basic principles, but I don't see it solving the issues of the interoperability piece. I have a couple of comments to make about EEs. There are essential elements of information needed to save lives and reduce morbidity and mortality. There are also EEs that people want at multiple levels jurisdictionally and sometimes they overlap exactly and sometimes they don't. I think our focus is going to be on not just health care delivery and disasters, which is already articulated in some of the bullets under the information sharing response and data coordination topic, but also our response data coordination having EEs as near real time or as real time as possible. There are a couple principles around that articulated in the proposed topics, but welcome entertaining others as well.

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Odessa Magafas: I wanted to flag another comment that agreed with aligning the PHEP Capabilities alignment. The next comment is the about the MOCC model with multi-HCC coordination and interstate coordination. The comment reads that information sharing is vital since disasters don't stop at HCC regional or state lines. We need a true multi-region multi-state planning.

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Richard Hunt: That reflects absolutely what we have learned on our call yesterday. When collaboration broke down because no one was accepting patients, clinicians went to Google to identify cities with hospitals to send patients. And that's a horrible place to be.

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Odessa Magafas: We have another comment here that states more funding for recipients would be required for their state to establish a MOCC. They don't have the authority on their own.

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Richard Hunt: That comment speaks to the challenges with patient distribution load balancing. Hopefully, I've articulated the concept here that you need to spread patients out. If you were to arrive at a surge hospital, you potentially have a one in four chance of dying. That's the bottom line to all this. You need to have a functional real time way of distributing those patients across wide vast areas. As we found in the pandemic, health care coalition and its geographic region alone doesn't work with pandemics that kill a million people. It's not sufficient, so you've got to cross multiple boundaries. It's a hard lesson we've observed and, hopefully, we've learned from it enough to come up with constructs that are effective enough to do patient distribution. It's got to cross boundaries; there's no question about that. Part of the discussion yesterday was about how some of the rural hospitals that aren't getting as many patients, can maybe take some patients and realizing their limitations as well. I'm glad to see the number of comments in the chat around patient distribution load balancing surge. It tells me people are thinking about this in a way that's productive. It looks like we're out of time for this discussion, Jennifer. I want to make sure that Jennifer has a chance to weigh in on this session before we jump to the next.

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Odessa Magafas: Yes, so Jennifer we can go ahead and go to the general Q&A unless you have any other additional things to add.

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Jennifer Hannah: I don't have anything additional to add. I want to thank Dr. Hunt for providing this overview and discussion. I want to thank everyone for your feedback as well and we want you to keep it coming. We'll certainly provide you with an opportunity to provide some offline feedback after you have another opportunity to read through the various topics. As Dr. Hunt said, what we've laid out for you are not the Capabilities. There's no overarching umbrella Capabilities that have been presented. We're trying to work towards getting the topics that may be included in the Capabilities right and we need feedback and appreciate it. When we first developed the most recent version of the Capabilities in 2017, they were informed by the HPP cooperative agreement. We have developed many more programs since the HPP cooperative agreement including the RDHRS, the hospital association awards, and so on and so forth. We want to make sure the Capabilities represent those programs as well, so it's not limited to just HPP. As Dr. Hunt has stated, these are national level Capabilities for the health care delivery system. Anything that's developed within these Capabilities, of course, will trickle down to any future program requirements set in place for our cooperative agreement programs. With that said, I will move to the general Q&A. This is an opportunity to ask any question. It's not limited to the presentations covered today, but you certainly may ask questions to ASPR TRACIE or Dr. Hunt.

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Odessa Magafas: Jennifer, we have one question. Can you share what the deadline is to submit the COVID supplemental grant report into the CAAMP system?

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Jennifer Hannah: We have not established that deadline yet. We are still working on getting our CAAMP back online. As you may have seen it's offline while we work through some of our procurement activities. We certainly will notify our hospital association recipients as soon as it becomes available. You can be assured we will provide you ample time to complete the reports within the system. To address an earlier general comment, the recording from last week's HPP cooperative agreement call will be posted in the next few days.

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Odessa Magafas: There was another question earlier about the BP 3 guidance and the flexibilities available on the ASPR website for HPP. Jennifer responded that the posting of the BP 3 requirements and flexibilities was delayed. We also have another question about an information session for the BP 4 grant application.

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Jennifer Hannah: We conducted that session last week and we will distribute the slides and the recording for that session. You can look forward to receiving that. If you have any questions, reach out to your assigned field project officer and they can assist you.

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Odessa Magafas: We have one more question. Are the FY 2022, HCC and HPP work plan templates and the HCC scope of work templates available?

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Jennifer Hannah: Yes, they are and Jenny you can reach out to your assigned FPO. All of the project officers receive the templates and you can request those.

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Odessa Magafas: We have another question from the Capabilities discussion. I am concerned that the use of a MOCC will hit a wall in those states where they are not the leads for response. Will there be considerations taken for those states where another state agency is the response lead and the HCCs are not recognized outside the arena of response support?

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Richard Hunt: The Capabilities need to be informed by experience. With reference to patient distribution, we have seen successes and we've seen failures. One of the things that evolved during the worst of the pandemic is the MOCCs. They are having some considerable success and being able to figure out how to do that will certainly be informed by the MOCCs. I would encourage you to look at some of the materials that ASPR TRACIE has on the MOCCs. I'll touch base with Jennifer about how we can socialize or get more information about how load balancing has been achieved and patient distribution has been achieved successfully. It's not perfect, but some have been met with considerable

success until when nobody would accept patients. Then things broke down with collaboration and those tended to be regional coordination sells as opposed to state. Well, I shouldn't say, as opposed to state, in addition to some state entities. There's an opportunity to learn more about what's been successful. Jennifer, I'll go ahead and pass it to you to close the webinar.

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Jennifer Hannah: Thank you to our attendees for your active participation and thank you to our speakers for your presentations. I want to remind folks to stay connected with ASPR on social media to receive the most up to date information about how ASPR is contributing to health care preparedness and response. I will go ahead and conclude the webinar for today. We hope to see you at the next quarterly meeting.