Virginia Department of Health Tele-Press Conference on
Virginia's COVID-19 Vaccine Developments
Moderator: Erin Beard
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3:15 pm

Coordinator: Thank you for standing by. Today's call will now begin. All lines are placed on a listen-only mode until the question-and-answer session. At that time, if you would like to ask a question, you would press Star 1 and record your name when prompted. If you need to withdraw your question, you would press Star 2. Today's call is recorded. If there are any objections, you may disconnect. And I will now turn it over to Erin Beard. Thank you. You may begin.

Erin Beard: Good afternoon, everyone, and thanks for joining our call today. My name is Erin Beard, and I'm a Public Information Officer for the Virginia Department of Health Office Of Communications. Today, we are joined by VDH Vaccine Coordinator and Director of the Richmond City and Henrico County Health Department, Dr. Danny Avula, and Virginia Secretary of Health and Human Resources. Dr. Daniel Carey.

Our subject matter experts are going to give an update on the latest developments with the COVID-19 vaccine. Today's call is being moderated by an operator. So when we get to the Q&A portion of the call, please follow their instructions to ask a question. Now, I'd like to welcome Dr. Avula to share a brief update. Dr. Avula?

Dr. Danny Avula: Yes. Thanks, Erin. Hey, everybody. Well, let me just kind of give a broad overview of where things are at with vaccination in Virginia. It won't be long, but I'm sure there's lots of questions and we'll take it in different directions.

But, you know, as of today, we have administered a total of 295,202 doses, and that is out of a total number of vaccines distributed to Virginia of 943,400.

We have been steadily increasing the number of doses a day. If you look on the Web site and you look at that seven-day moving average, it has gone from, you know, just a few thousand a day now to over 14,000 a day. And that doesn't even take into consideration what we've seen the last three days. I think, both as vaccination has scaled up around the commonwealth, but also as we have gotten better and more assertive about making sure that the data is actually enrolled in our state database.

We've had three consecutive days with over 20,000 doses administered each. And so, things are absolutely moving in the right direction. As we look around the Commonwealth, we see fantastic examples of health departments, health systems, different partners joining together to get many people vaccinated every single day.

You know, there are two distinct issues that I see with vaccination right now. One is the clarity around the difference between our doses administered and our doses distributed. So that 295,000 doses that we know have been administered, because they have been logged into our state database and the total number of doses distributed, that 943,000, which portrays how many have actually come into Virginia.

So, there's a gap there, and I think that has led a lot of people to ask questions. What is going on? Are doses sitting on shelves? How are we not getting doses to the people who need it? And so, we can talk through some of the details in that gap, and I'll do that in a second, but that's the first distinct issue.

The second distinct issue is, how do we make sure that the new vaccine that

we're getting each week, is also being distributed through those right channels and getting out to as many people as possible? Now, there's about five main ways - well, I'll say four main ways right now that vaccine is getting out to the community, primarily through hospitals, through health departments, through private providers, through pharmacies, and then also through the long-term care facilities.

So, many of the nursing homes and assisted living facilities, they are being prioritized, as they should be, since we have seen COVID's devastating impact in nursing homes and assisted living facilities over the last year. They are being prioritized, and that is being handled through a channel where the federal government has contracted CVS and Walgreens to just work through those communities.

The - and that vaccine, we don't have much control over. That is allocated directly from the federal government. Of our 943,000 doses, that accounts for approximately 226,000 of those doses. And so, that is being managed by CVS and Walgreens, and they have scheduled all of those facilities. They're going to go through those long-term care facilities three separate times for first doses and second doses and anyone they've missed. And right now, you know, those three visits are being scheduled between now and March.

When we think about the other channels, hospitals, health departments, providers and pharmacies, the vast majority of our vaccination in Virginia, has happened through hospitals. Again, because of the high risk category that healthcare workers are in, they were included in that Phase 1a.

and so, much of the vaccine early on went to hospitals, and they did a fantastic job of getting through their staff, their providers, and that includes not just the doctors and nurses who are taking care of patients, but also their, you know,

other staff who have patient contact, so their dietary staff that are delivering meals to hospitalized patients, the custodial staff that are turning rooms over as patients come in and out.

So, a large number of our vaccinations, 145,000 of our 295, have come from hospitals and health systems that have vaccinated their staff. And then we have increasingly seen vaccines go to some of these other - through these channels, the local health departments that are standing up large points of dispensing, which we call PODs, through private outpatient docs that are getting it to their patients and that are helping with getting through the 1a and 1b populations, and then through pharmacies as well.

So some of the news in terms of where we are in terms of vaccination, several of the communities around the Commonwealth have progressed from that 1a priority group for healthcare workers and long-term care facility staff and residents, to Phase 1b, which includes much of the essential staff that we - our society can't move forward without.

So, folks like the police and fire and teachers and childcare workers, folks who work in food service, either through restaurants or through grocery stores, or work in the agricultural industry to support our food production. In addition to that, initially that included - vaccines 1b included individuals who were 75 and older.

earlier this week, the federal government Department of Health And Human Services, gave pretty clear direction to all of the states, to the governors, to include individuals who are 65 and older, and adults who are ages 64 down to 16, who have underlying conditions.

And while they encouraged that movement in the states, they also intimated

that there would be a large release of second dose reserves. So remember that this vaccine is a two-dose vaccine, and the way the federal government had been allocating that, they'd been sending out first doses and holding back second doses, and then administer - delivering those second doses to different providers as they came up ready to do that round of second doses.

And so, we were hearing very consistent messaging from the federal government that all of those doses were going to be released. As a Commonwealth, we decided to follow the federal government's lead to add those 65 and up, and those with underlying conditions to our Phase 1b.

and then over the last couple of days, we have heard very different messaging, and we're not exactly sure what to do with that, but the sense that that may not actually be the case, that our allocations may not have to be increasing, is what we're hearing, and it's certainly disconcerting and disheartening, given that we made the step forward to include, to expand our 1b under the assumption that we'd be receiving more vaccines.

So now we're in a situation where we are getting about 100,000, 110,000 or so new doses a week, and all of that supply is being doled out as quickly as possible to those channels that I mentioned, to the hospitals, to the health departments, to providers and pharmacies.

The state is not holding back any of that vaccine. It's all being sent out to providers. And then - and so - and this week, just as an example, we had over 300,000 dose requests, yet only 106,000 doses to allocate. And so, already we have seen the tremendous demand and the tremendous ability to receive vaccine and to get it into vulnerable populations as quickly as possible.

If that continues, you know, if we continue to see our supply come in at about

between 100 and 110,000 doses a week, what - the question you're probably all thinking is that it's going to take us a long time to get to 25,000 doses a day or 50,000 doses a day, or - and that's not maybe possible with the supply that we're being provided, but it's also going to take a long time to get through all of the residents of Virginia. And I do feel like that's the challenge of where we are.

Now, the other - the first issue that I described, the gap between the 295,000 doses administered, and the 943 doses distributed, is something that I've been trying to get my arms around over this past week. And as I said, about 226,000 of those doses are out of our control. That's what's the CVS and Walgreens have. It's what they are giving on a schedule, to the long-term care facilities.

The rest of that is - you know, what we've identified is that there are a large number of doses that actually have been given. They've actually been administered to vulnerable populations, but there's - but that data has not been entered.

And so we are working to find data support for providers, for health departments, for health systems, who have actually been doing the work of getting people vaccinated, but have not been able to catch up with the data. And so, what we're really clear about now is that our future allocations, our ability to get more vaccine into Virginia, is really going to be dependent on having clear, accurate data, and knowing exactly how much vaccine has been used.

I think we've seen that as we've seen the big increase in doses administered over the last few days. That is representative of a lot of the data backlog that we're catching up on. But then there's a portion, I would say probably a

couple of 100,000 of those doses that are with providers, health systems, and health departments, that has - that are building up the capacity to provide that vaccine.

I will also say that the - some of those communities being in 1a, has actually been a limiting factor for those health systems and providers to get vaccine out, because in some communities around the state, they were able to meet that 1a demand very quickly, and then have felt like they weren't able to progress to the more expansive 1b population without a clear directive from the state.

Now, you heard from the governor and from others that we need to be as flexible as possible. We need to get this out. If we finished our 1a population, let's find other ways to get to the 1b population. I think that that has been - without a clear designation for certain communities, that's been a sticking point.

And so, I expect that, you know, at this point, 11 of the health districts have moved to 1b. I anticipate most of the state will move to 1b next week, if not all of the state. And so, still kind of touching base with some of those districts to see where things are at. But I think that restriction or that sense of not being able to move forward, will be removed and we'll see a lot more vaccine flowing next week.

So, I'll pause there and see if Secretary Carey has other thoughts or anything she'd like to add. And then Erin, we can go to questions from there.

Dr. Daniel Carey: Sure thing, Dr. Avula. This is Dan Carey speaking, and thanks for that great introduction and review of where we are. And the only thing I would add is

that I do think that we're in this situation in which, yes, we have doses that are unaccounted for, and Dr. Avula has gone through all of that.

And we have confidence there are also doses that simply need to get into individuals' arms. And getting all folks to 1b as quickly as possible, has been what we've heard from the vaccinating community, would be most helpful in that, yes, we want folks to follow the phasing to get to the most vulnerable and those caring for the most vulnerable first, but that wasn't - it was inhibiting folks from, again, feeling comfortable, feeling secure that they weren't breaking the rules and that they were holding back because they wanted to act as good stewards of those scarce resources.

So the feedback, and this is across the country, was to make sure that there was flexibility, that getting into 1b so that these vaccination events always had enough individuals able to be identified, scheduled, and vaccinated. So, I think that is one point.

And then secondly, as Dr. Avula coordinates all of the vaccinating communities that he's referenced, down the road, unless there's a significant increase in supply from the federal government, from production of the current vaccines, or because new vaccines, whether it's AstraZeneca or Johnson & Johnson, them coming online as well, we will have all of these developed mechanisms to get vaccines out, but we will be limited then by that dosing of 110,000 or so that we're being allocated by the federal government.

So we're in that situation. Yes, we want to (gear up) very quickly. The numbers reflect that. And also, once we use up current supply, we're going to have to live within that weekly allocation. So that will breed some frustration because we are encouraging health systems and all the different groups that Dr. Avula mentioned, to build, build, build, to use up everything we have in a

way consistent with our phasing model, but also with the knowledge that we will - when we use that up, it's not going to be an increasing supply likely until March from the current information.

We hope there's some upside surprise, but that's what we're getting from the federal government. So, we'll all stay tuned, but we have - we're in that situation where we want to speed up, even though we know we'll have to hit a steady state of incoming doses per week.

But that doesn't mean we don't - as Dr. Avula said, need to build up the capability of not just doing 25,000 a day, but 50,000 a day. So with that, as soon as those types of volumes are available, they'll rapidly get into Virginia. So back to Erin.

Erin Beard: Great. Thank you so much for that update, Dr. Avula, and Secretary Carey. Before we begin the question-and-answer portion of today's call, I'd like to remind everyone, our call is focused on the latest developments with COVID-19.

For questions regarding other topics, or if our subject matter experts are unable to answer your questions today, please email them to the VDH communications office. Contact information is available at vdh.virginia.gov/news.

Please remember to limit your inquiries to one question and one follow-up per person to allow time for everyone. Now, we'll begin the question-and-answer portion of today's call. So, Operator, if you'll take over.

Coordinator: Thank you. We will now begin the question-and-answer session. If you'd like to ask a question, please press Star 1, unmute your phone and record your

name clearly. One moment, please, for the first question. Our first question comes from Mike Still. Your line is open.

Mike Still: Thank you. Dr. Carey and Dr. Avula, in Southwest Virginia, specifically the three westernmost health districts, what's the situation looking like in terms of supply and availability in those three districts, and in terms of setting up mass clinics?

Dr. Danny Avula: Sorry. Can you clarify, Mike, when you say the westernmost districts, are you about like Lenowisco, Cumberland Plateau, and Mount Rogers?

Mike Still: Exactly. Yes.

Dr. Danny Avula: Got it. Thanks. So, you know, I know that both the health department and Ballad and some of the other providers out there, have certainly received vaccine, are doing large-scale clinics. I - if you give me a few seconds, I can try to pull up more clarity on just how much vaccine has been used.

So it looks like in Cumberland Plateau, we're looking at about, you know - there's about 6,000, maybe more, 7,000 doses that have come to that part of the community. I don't have great breakdowns on - the total administered now is in the couple of thousand range. And I know that they've got multiple closed PODs.

And so, let me just clarify that terminology. A POD is a point of dispensing. When we do a closed POD, typically we are pursuing a very particular subpopulation. And so, for example within our 1a communities, we were doing closed PODs with healthcare workers.

Now that that part of the state has opened up to 1b, there will be closed PODs

with the specific populations in 1b. So with police, fire, teachers, and kind of working through that order, with individuals who are 65 and up sprinkled in there as available.

And then we're - so that's the approach. And I know that that - because the decision to go to 1b happened, you know, for Southwest Virginia last week, there's still a lot of closed PODs. And that happened before the addition of the 65 plus.

So obviously, that infused a number of new Virginians who qualify into 1b, and the health departments and other providers are going to need a little bit of time to adjust to be able to open up to that population. So I anticipate, if not next week, then the following week, we'll see more slots for those new entries to 1b.

I will just remind all of us that this - the circumstances under our expansion to 1b, occurred with the hopes that we would be receiving a lot more vaccine. The reality that we are not going to be seeing that likely, does mean that there's still a constrained supply and a lot of demand.

And so, I hope that in that part of the state, as well as, you know, everywhere, that we really still allow our - the folks who are most vulnerable, the folks who are really, you know, at highest risk of COVID complications, of hospitalizations, and of deaths, that we allow them go first.

And so we - I think we're trying to do this dual strategy, where we make sure we get our essential workers so that parts of our society can open back up, but also we can get to the most vulnerable, and that is - it's quite a challenge, given the constraints of vaccine supply that we're seeing.

Mike Still: Okay. Thank you. I appreciate that.

Coordinator: Thank you. Our next question comes from Kate Masters. Your line is open.

Kate Masters: Hi. Thank you both for doing this. I just had a question about the, you know, sort of change in communication that we seem to be getting from the federal government over the last couple of days. I've seen reports that there actually is no, you know, reserved second dose of vaccines that can be released.

So I guess my question is, A, will that affect Virginia's decision to expand the 1b population? And then I'm also wondering, if there's no second dose stockpile that will be released, does that affect us logistically in the sense that we're going to need to start thinking that the doses we are getting, need to be dedicated to people who have already gotten that first dose, if that makes sense, to make sure that they are also able to be fully vaccinated.

Dr. Danny Avula: Yes. So I think that it is super confusing for us too, Kate, right? We've heard initially that we were going to get this release of second doses. We then heard more recently in the headlines that there is no reserve of second doses, and we really don't know exactly what to make of that.

What we do know is how much vaccine is actually getting allocated. And so, for this week, we received 106,000 doses. And I should be clear that those are first dose, because the federal government is allocating second doses through a separate pathway.

So anybody who has received first doses, is automatically getting assigned a second dose allocation above and beyond our 100,000 or so doses per week. So this week we received, like I said, 106,000 first doses. And then in addition to that, there were 61,000 second doses that went directly to those

providers who administered or received first doses either three weeks or four weeks ago, depending on whether it's Moderna or Pfizer.

So, you know, I mean, for all intents and purposes, at least this week, there was a separate store where second dose vaccine was being distributed. Next week may be a different story. And obviously we'll have this conversation again, depending on what that allocation look like.

So, how are we handling second doses? I mean, the intent of the way the federal government is distributing those doses, is really to ensure that there is vaccine available to complete that 95% plus protection. And so our - what we're asking of our providers is, when they receive that second dose, to prioritize it for individuals coming back for their second dose.

Now, we know that not everybody will come back for second dose. And so, what we're saying is, use the vaccine that you have, work through all the doses. If your second doses don't show up or don't schedule appointments, go ahead and use that for first doses, and then we'll figure out how to ensure we can get the second doses after that.

But right now, the imperative is really to use all of the doses you have, and we'll keep allocating accordingly as it comes in.

Kate Masters: Okay. And a follow-up question to something you mentioned earlier. You know, you said there were some health districts who didn't feel comfortable, you know, moving forward with vaccinating that second stage, because they hadn't officially gotten that 1b designation. And so, who actually gives that? Like, how do communities get the go-ahead to move into that phase?

Dr. Danny Avula: Yes. Sorry, I should clarify. Probably not health districts that have that hesitation. More providers and health systems, because ultimately it is the health district that decides whether we're through enough of our 1a population to go to 1b.

So in communities that were in 1a, there were health systems, health - and other providers and pharmacies that received allocations that may not have been - have felt the freedom to start vaccinating the 1b population because they hadn't - their community hadn't moved there.

Kate Masters: Okay. Thank you.

Coordinator: Thank you. Our next question comes from Julie Carey. Your line is open.

Julie Carey: Hi. you're probably aware that in Fairfax County, the health department has just in the last 24 hours, sent out messages to people who received first shots, telling them that there is not enough vaccine right now for their second shot. How much does that concern you and what do you say to those folks who are now wondering about whether they'll be able to get their second vaccination?

Dr. Danny Avula: Well, I did speak just recently to the Fairfax County administrator, and talked through how much vaccines will actually be coming to Fairfax County this week. I think it more than covers any potential second doses. I think we will have to look more closely into why the second dose allocation didn't come directly from the federal government in that case.

And I don't know the answer to that right now, because as I said, what's been happening is that any entity that receives a first dose, automatically gets

queued up and allocated by the federal government. Those second doses are - for Pfizer, it's three weeks, and for Moderna it's four weeks.

So that happens above and beyond what we're able to allocate. So I don't - we're going to need to better understand why that second dose allocation didn't come on the timeframe that it was supposed to. But there is a large amount of vaccine coming in to Fairfax County and to the health system there for - that should be able to meet some of that need this week

Julie Carey: And a quick follow-up to that. You know, given what we've learned in the last day or so, is there any rethinking about the expansion of 1b to include the 65 plus?

Dr. Daniel Carey: Danny, I may take that. This is Secretary Carey. I think that we're always thinking about how to operationalize this best. And I think, again, even before we heard about a potential rise and then a potential fall in, you know, new supplies, it didn't influence us, but we were considering that anyway, because the providers were saying that they were - it would help them to have larger groups prioritize so that they can be 100% sure when they had a clinic, they always had enough people there to use all the supplies and that they could have larger events to be more efficient.

So, I think we'll continue to monitor that, but I don't see at this point that we're recommending backing away from 1b. but at the same time, within 1b, just like first responders were the priority on the worker side, and the 75 and older are the priority on the individual side, we're continuing with that, make sure, as Dr. Avula had indicated, that even though there may be a bigger pool, that we want to still use the priority lists.

But if, again, on an operational level, you have additional doses, you have a

large event that you're not confident that every dose will be used, make sure that you market it to those folks within 1b. And I'm sure Dr. Avula, you have additional thoughts on that.

Dr. Danny Avula: I mean, maybe the only other thing I would say is a reiteration that, even if we stay in 1b and we're - and we have much more demand than supply, I think there is, you know, just a plea to our community to recognize that there are people who need it more than us.

And I'll just give myself as an example. You know, I'm 42 and I'm a healthcare worker and I'm in the 1a population. I absolutely will get vaccinated, but have not done that yet. And I think, given where we are with supply, there are many elderly folks who are at higher risk.

I can do most of my job remotely. And so, I just would ask that people kind of think through that. You know, if you can continue to do the things that we know work to prevent the transmission of disease, if you can work from home, if you can - you know, if you consistently are wearing a mask and social distancing and doing all the things that will help you prevent you from getting COVID, let's let the folks who are going to be most susceptible to this disease get vaccinated first.

And I just think we're going to have to allow for that to happen, given the fact that we're not going to get the doses we need likely for a few months.

Julie Carey: Thank you.

Coordinator: Our next question comes from Lillian Wise. Your line is open.

Lillian Wise: Oh, hi. It's Lillian Wise. So you said, sir, that you had orders for 300,000 doses, and you've got 100,000. So that's three times as many as what you have. Could you talk a little bit about how you're going to make sure that these are equitably distributed across the state, and also what kind of safeguards are in place to make sure that they are going to the priority populations?

Dr. Danny Avula: Yes. Thanks, Lillian. So in our allocation this week, obviously we couldn't meet all of the demands that came. So there's a couple of things that we look at. One is regional distribution, and we - that we kind of analyze per capita, by region, how much each district and region is getting.

And we try to align that, and it's not perfect, you know, partly because the design of how that's allocated. So, I'll just - I'll give an example of, you know, in Norfolk, right? Right now, it looks like Norfolk has a much greater distribution of vaccine than their population would otherwise dictate, but it's because one of our largest health systems, Sentara, is addressed in Norfolk.

And so all of the doses that went to Norfolk, are assigned to Norfolk, but we know that that's not the case. So there's a little bit of flexing that's done there on - based on situations like that. But what we try to do is ensure that there is - you know, we look at each district and how much per capita they should be expected to receive.

Then we look at how many doses have been allocated thus far, and how many doses have been administered? And that was kind of a newer, because this is the first week that we've had that scenario. This is the first week where we've had way more demand than we've had supply.

And so we - basically any provider that had over 40% administration, we tried

to meet their full requests. Now, there are challenges to that too, because I think in a lot of cases, you know, one of the things I said earlier in this call is that the data entry piece is critical.

And I think a lot of our providers, either because of the systems that they were using, you know, the CDC initially gave us this VAMS system that has proven to be slightly problematic. Sometimes the registration systems that some providers are using, don't feed directly into our state-based database, the Virginia Immunization Information System, VIIS.

And VIIS is our source of truth, right? Like that's how we know that a dose has been administered is if it's been entered into VIIS. That is also what the federal government is using to look at our doses allocated versus administered.

And so, you know, right now, I recognize that there are a lot of providers who have, like I said, given a lot more vaccine than the data shows. But we, you know, we've got to get the data piece right. And so, you know, in places where we have administered a lot of vaccine, if it's not happening through the medical record or through the technology, we've got to do a manual entry into that VIIS database to get those numbers up.

And like I said, I really do think somewhere between 100 and 200,000 of the doses on our docket, are doses that have been given, but not administered. So that - but back to your question about allocation. So we look at - you know, providers that have given more than 40% allocation, would get most of their requests.

Providers that have given under 20%, will have a greatly shortened amount. And then we looked at how much supply each requesting provider had on

hand. And so, with those factors of trying to do equitable geographic distribution, looking at the performance, and looking at the amount of vaccine on hand, we did our best to parse out that 105,000 doses for this week.

Lillian Wise: Thank you. So my follow up, just with that, is that, you know, the districts also have to be planning ahead as to how many people they're inviting to these clinics and how they're going through the priority lists. Will there - given the limitation in the number of doses that are coming a week, and as others smooth out their data, they may be able to get more doses. So how did - how should the health districts plan as far as continuity as to how many doses they'll be getting each week?

Dr. Danny Avula: Yes, great question, and it's been a big challenge because our information about how many doses we're getting, changes up to the day of order. So we will do our best, but that is - what we've not done, but will do, is kind of - is put that out to the districts that, hey, right now, we're expecting, let's call it 100,000 doses.

The next day, if that changes, we'll say, hey, it's looking more like 80,000 doses. You just may have to expect some variability. So we've got to figure out what the right - like is it worth people going through the rollercoaster that our allocation team has had to be on every single day? I don't know.

I think there's just a reality to the district planning event that has to take that into consideration. The other piece of that variability is in the discrepancy between the date, like what our system shows and what a provider says they've done.

And so, what we're going to start doing this coming week is, on Monday, we're going to send out to our large providers, hey, here's what we have. Here

are the doses you've been allocated. Here are the doses you administered. And there will be a much more bi-directional, hands-on process that occurs throughout the week to make sure that we have the data right, and that we have clarity and accuracy about just how much vaccine has been administered.

We've now onboarded a team of 10 new individuals to do specifically that function, to really work with these providers and ensure that the data is correct, and to troubleshoot where it's not. So that team will go into action next week.

And I do expect there will be a much more robust conversation and more clarity on who's entered data and who hasn't and how do we support that effort, that we can get to as accurate numbers as we can with the total amount that we've had allocated.

Coordinator: Thank you. Our next question comes from Ryan Gabrielson. Your line is open.

Ryan Gabrielson: Thanks for taking the question. What is the process and schedule for ordering second doses? And to what extent is it different from ordering first doses?

Dr. Danny Avula: So the first dose allocation comes to us, as I said, it does change slightly every day. At some point, you know, probably Wednesday or so, we were looking at 80,000 doses. By Thursday, that had bumped up to 106,000. So there's variability in what the federal government is coming to us with, which complicates things.

But then there is a separate allocation for the second dose. So, this week, 106,000 first doses, 50 - sorry, I forgot the number, 50 - 61,000 second doses.

So, the second doses are required to be distributed to those who have already received first doses at the correct interval.

So, let's say I am a large family practice in Winchester. If I get 1,000 doses of Pfizer vaccine, then three weeks later, which is the time period between the administration of the first dose, I will automatically be slated for 1,000 doses of Pfizer vaccine that are held for the second dose.

So that's how it has been working over the last couple of weeks. Again, given all of the kind of cross messaging we're hearing from the federal government, I don't know if that's going to be the situation next week. But if it is, then that second dosing will be in addition to our 100 to 110,000 dose - first dose allocation.

Ryan Gabrielson: A quick follow-up related to the uncertainty in allocation. What does that, specifically in the miscommunication, do to your ability to prepare and plan next week, two weeks from now, three weeks from now?

Dr. Danny Avula: Well, there's definitely no planning three weeks from now. I mean, I think all we can do is continue to build the infrastructure, the vehicle for vaccine delivery. You know, to get to some degree of herd immunity as a Commonwealth, we need to get 70 to 80% of our population vaccinated.

When we originally set targets, we looked at how many adult Virginians there were, tried to get to 80% herd immunity. We scoped out about 50,000 doses a day. That’s what it's going to take to get to that number. And so, we are building the vehicles to get to that number.

We're expanding the number of practices that have gone through the CDC approval process, the number of pharmacies. Health systems continue to

pledge their support to be able to do large-scale vaccination. Health departments are doing mass vaccination around the state.

And then there will be this need for a fifth channel, which I've mentioned at different times, which is, you know, a fixed site, large scale, mass vaccination effort, you know, six, seven day a week operation, where we're doing somewhere between one and 2,000 doses a day, is what we would deploy the National Guard into - VDM is already planning where those sites will be, and what the staffing models will be, and how they would be staffed.

But that is - I mean, it's an important thing for us to plan for and build, but it isn't - right now, it doesn't matter because we're not getting anywhere near the vaccine supply that we would need to use that channel. It will be built. It will be ready as we move towards March and April, where, you know, we expect more production from Pfizer and Moderna, and then AstraZeneca is completing clinical trials over the next month or two.

I anticipate April is probably the earliest time we would see AstraZeneca enter the US market here, but that will increase supply as well. So we have to build the vehicle to get vaccine out. It is extremely difficult to actually plan operationally in terms of registering patients for clinics two and three weeks out. And so, we're really only able to do that for the upcoming week once we know our allocation.

Coordinator: Thank you. Our next question comes from Trevor Stafford-Walter. Your line is open.

Trevor Stafford-Walter: Hi, this is Trevor with WJLA. My follow-up was about the Fairfax County situation, mainly wondering, did they not get any of their traditionally provided second doses allocated, or did they just get a smaller number? And

if they didn't get any, is there some sort of contingency planning going on for a situation where second doses fall off? And would that cause sort of stopping of new vaccinations so that the newly received vaccines are going to people who've already gotten one dose, but not two?

Dr. Danny Avula: Trevor, I'm not exactly sure - as I'm looking at it, there's no specific second dose allocation. Let me actually make sure that's right. That is not correct. There's about 7,000 second doses coming to Fairfax this week. So, I don't know how many second doses they were anticipating, but there was a segment of second dose allocation that is coming to them this week.

In addition to that, they're receiving a large number of first doses. And so, to your question of if not enough second doses are coming, what then do we do? I think our options are either to reallocate some of the first doses for that need, if we have more than 7,000 folks who are showing up for second doses, or to look if there's any other opportunities for redistribution from other providers in the area, or other providers outside of the area who may have more vaccine than they need right now.

So, that actually is a good segue into a really important function that we are now more able to do, which is kind of the air traffic control role. Like now that we know where the vaccine is, we have more of a sight line into who has vaccine, what their plans are to get it out in a given week, there is more of an ability to say, okay, provider X, if you can't get through all of this vaccine this week, there's a place that needs it badly. Let's ship it up there. So, there's another layer of analysis and logistics that we're putting into our process to be able to move that vaccine around.

Coordinator: Thank you. Our next question comes from Jill Palermo. Your line is open.

Jill Palermo: Hi. Thank you for taking my question. I was wondering if you could tell us, as much as you can, about what determined our Virginia's allocation of 100 to 110,000 doses a week. Like, how is the federal government determining that that is what they're giving to Virginia? And is that number impacted by our data input struggles?

Dr. Danny Avula: I will do my best and see Secretary Carey has any additional thoughts. I don't know how they're determining that 100 to 110,000 first dose allocation. I suspect there's some population, you know, I think they're looking at their production every week, and that they're looking at, you know, what's the population of each state and determining our allocation based on that.

There has been messaging from the federal government that our future allocations will depend on our ability to get it out and to people. And so, it's why I keep driving, yes, it's vitally important that we get as much vaccine administered as possible, but if we don't get it into VIIS, that is going to impact our future allocations.

So, again, I don't have - that hasn't been clearly dictated by the federal government, but we've certainly heard that messaging consistently from HHS. And so, we've got to be prepared for that. And I think the only way we can be prepared for that is by really executing well, not only the administration of the vaccine, but also the data entry.

Jill Palermo: Okay. Thank you. And a quick follow-up question. Sorry, go ahead.

Dr. Daniel Carey: This is Secretary Carey. Just to add on, Dr. Avula, you'd asked, in our calls with Secretary Azar and the HHS and the Project Warp Speed folks. It really is exactly as Dr. Avula - there aren't favorites amongst the states. They're population based, and there are a separate allocation for federal entities and

several other entities, including the Indian Health Service and some other populations.

So that is set by populations. And then it's more of a warning that in two weeks' time, if folks have not gotten - used their doses - you know, you have - always have some pipelines, so you're not going to use 100% of your doses. And there's the part at CVS and Walgreens that their contract has at least two weeks supplies out and actually has more. That's not going to be affected.

And so the federal government has given that warning, put us on notice, not us, the entire country. And we are responding, as Dr. Avula has indicated. They haven't indicated exactly what that is, but we want to make sure that we're using everything that Virginia has, and that we want to make sure that that's not going to get in the way of any future doses.

So, that's our current understanding. And again, what we can control is making sure that every dose that we've gotten, has - is getting - all of it is out into the providers' hands already, but to encourage, what are the impediments that we can work on? And Dr. Avula has been outlining all of those things to do, to encourage all of those doses to get from shelves, in providers possession, into the arms of Virginians.

Dr. Danny Avula: And Jill, it's Danny. I'll add one more thing. I've heard a couple of rumors circulating that - you know, I've heard from a couple of our elected officials that perhaps Virginia isn't optimizing our order. And I just want to assure everybody that that is absolutely not true.

We are scraping and clawing for every dose we can get. We are maximizing our order every week. And we've seen some data that's - from HHS that says

that states are only asking for about 75%, and that certainly is not true for Virginia.

Jill Palermo: Okay. And you talked about a March-April timeframe for getting more vaccine. I wonder if you could talk, I mean, at, you know, a greater rate, can you tell us what that (unintelligible) based on? Why do you think we won't get more - significantly more until March and April? And do you have any reason to believe that the Biden administration will change that?

Dr. Daniel Carey: Maybe …

Dr. Danny Avula: Why - go ahead, Secretary Carey.

Dr. Daniel Carey: Well, I'll just say that the basis that I have for - that we have for saying that, is that General Perna called Commissioner Oliver on Thursday, yes, on Thursday following the - two days after the press conference, to walk back and to re-clarify that there aren't - there is not warehouses full of frozen vaccine to distribute. It's all based on just-in-time production.

So it's based on that conversation, and that we should expect the current allocation in the 100 to 110 doses per week, with additional doses for second doses. But as we asked, if we were to - for example, next week, we're ginned up a lot.

If we did 250,000 doses in one week, I don't think that will occur, but I don't think there is second doses for all of those three or four weeks later. So those details and logistics at the federal level, are also being worked out. So that's why we're repeating what the leadership from the federal government is sharing with us.

And, you know, we're going to continue to listen and to learn along with them as to how they can meet that demand. They have not indicated until new vaccines are on - that are approved and available, will it go up, or that's the timeframe where additional production may be available, but they felt pretty confident that without new vaccine, that's what we should expect until the end of February and early March. And Danny, you had some comments as well.

Dr. Danny Avula: Nope. That's great. You covered it.

Jill Palermo: Okay. Thank you. So a new vaccine, meaning like new companies making - new companies' vaccines coming out?

Dr. Daniel Carey: Whether AstraZeneca or Johnson & Johnson, exactly.

Jill Palermo: Yes. Thank you.

Coordinator: Thank you. Our next question comes from Emily Swecker. Your line is open.

Emily Swecker: Thank you. My question is, and you kind of touched on this, but many places are now moving into Phase 1b, but they tell us they are still trying to get shots for folks in Phase 1a. So can you just explain what the plan is to get those places caught up so they can get into that next phase?

Dr. Danny Avula: All right. Let me repeat the question so I understand it. Places that are moving into one - you're asking what we can do to get folks caught up so that they can move into 1b. Is that correct?

Emily Swecker: That's correct.

Dr. Danny Avula: Well, so I think it's identifying where those 1a providers are, because, you know, as I was speaking earlier about that the hospitals and health systems that have just turned through their staff, everybody who wants the vaccine, the health systems have done a fantastic job of getting vaccine to them.

Some of those health systems are now shifting to providers and have been doing this over the last week or two, providers outside of their health system. And that can be a large group, because it's not just your primary care or outpatient multi-specialty practices.

It's also home health providers, you know, folks, nurses that go into people's homes and do care, you know. So there's a number of people that are not affiliated with health systems that would fall into that 1a population. There's another segment that includes group homes and other kind of congregate care that would fall into that 1a category.

So it really is about identifying where those individuals are, and figuring out how to get them into clinics to get them vaccinated. And so, that's what you see happening this past week, and this upcoming week in those 1a communities, is closed PODs specifically for those subpopulations. And then when they feel like demand has been met, they can move on to 1b.

Now, we also recognize that the restriction of that, like having to go and find those individuals, has impacted our ability to get vaccine out quickly. And that's why the flexibility to move to 1b, knowing that we're not leaving 1a behind.

We're going to be doing 1a concurrently, but we've got to be able to not slow down our ability to administer a vaccine because of those types of restrictions.

And so, as I said, I anticipate much of the state this week, will be moving into 1b, and that there will be really optimal flexibility to ramp up vaccine outside of just that 1a category.

Erin Beard: Hi, everyone. I just want to jump in. This is our five minute warning before the end of the call. So we have time for one final question.

Coordinator: Our last question comes from Kate Andrews. Your line is open.

Kate Andrews: Hi. Thanks for doing this. I wanted to ask about people in group A who are saying that they don't want vaccines. Is that a significant number in Virginia? Are you finding people who are saying no, we're too nervous?

Dr. Danny Avula: Yes. You know, I think the reports from our health systems have been that in that round one, about 50 to 60% of their healthcare workers and staff are wanting to be vaccinated. What we've also heard is that after the first round, many of those healthcare workers who were waiting and see, have watched their colleagues get vaccinated, have watched their colleagues not have any side effects, and they've said, now we're ready.

And so I think there'll - there is currently just another surge of 1a's that will be coming through and getting vaccinated. But, you know, it's not 100%. And so, we'll have to see how those numbers trickle out. Obviously, there's a large amount of vaccine hesitancy across the board.

Prior to us actually having vaccine, there were a number of surveys that were done that showed that about 60% of the population was ready. And then when we stratified - that's actually - it's more like 50% overall. Over 60% for the elderly, lower numbers in younger people.

And so, you know, I think there will be a point in a couple of months where this supply-demand curve completely shifts. And it will be us working to help address vaccine hesitancy, to get as many people to actually come and get the vaccine that will then be available so that we can reach our herd immunity goals.

Kate Andrews: Is there any restriction or, you know, issues with people who are working in healthcare professions that refuse to get a vaccine? Can they lose their jobs or be transferred to other places or something else like that? Is that under consideration right now in Virginia?

Dr. Danny Avula: Right now, the vaccine is under what's called an emergency use authorization from the FDA. And at least in Virginia, there is no way that we can mandate vaccination as a condition of employment or anything like that. So there will not be any way to do that.

Now, organizations may have the flexibility to adjust their policies, and really haven't gotten there. I think that the inability to do a mandate based on EUA, would probably preclude that, but there may be some ways that organizations would opt to shift their staffing or shift their (unintelligible) vaccinated.

Dr. Daniel Carey: And I'll add to that in that a couple of points that, you know, to build confidence and to - you know, we want carrots, not sticks at this point, given all of the rhetoric that has been given by - about the - first of all, the disease being a myth, and it's all a hoax.

We really want to be sensitive to that. And we think that peer pressure is our most powerful tool. And Dr. Avula indicated that, and that's - we've heard that from many, many health systems, that the second dose for the unit is

when a lot of the folks who were hesitant the first dose - are actively getting their first dose.

And I'll also say that the reports from our skilled nursing facilities, some of, you know, arguably the most vulnerable individuals, that staff do have hesitancy and seeing around that number, again, it's anecdotal - we don't have a final report and surveys in, but that anecdotally, on the resident side, the vast majority of our elderly are saying yes, and that's really good news so - that the most vulnerable are saying yes to the vaccination.

However, we know that the virus can be transmitted by younger, healthier individuals, especially staff. So we've got to work on both sides, but the good news is that most seniors are indeed saying yes to the vaccine, and we really need to encourage that amongst other populations.

Erin Beard: Okay. I want to thank everyone for joining our call today. There will be an audio recording posted on the VDH Web site, as well as a written transcript. You'll be able to access these documents at www.vdh.virginia.gov/coronavirus/media-room. There will be a digital copy and transcript of the call posted there. Once again, if we were unable to answer your question today, please email them to the VDH communications office. Thank you and have a great rest of your weekend.

Coordinator: Thank you for your participation in today's conference. Please disconnect at this time.

END