

**Virginia Department of Health Tele-Press Conference on
Virginia's COVID-19 Vaccine Developments
Moderator: Melissa Gordon
January 29, 2021 3:00 p.m.**

Coordinator: Welcome, and thank you all for standing by. At this time, all participants will be in a listen-only mode until the question-and-answer portion of today's conference. During the question-and-answer portion. If you would like to ask a question, you may use Star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn the conference over to Melissa Gordon. Thank you. You may begin.

Melissa Gordon: Hi. Good afternoon, and thank you for joining our call today. My name is Melissa Gordon, and I'm a Public Information Officer for the Virginia Department of Health Office Of Communications. Today, we are joined by State Vaccine Coordinator, Dr. Danny Avula. He will 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 part 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. Danny Avula: Thanks, Melissa, and good afternoon, everybody. Just wanted to kind of hit a few of the high points of where we've gone with vaccination this week in Virginia. As of this morning, we have 697,914 total doses administered. That has been just an incredible amount of work over the last few weeks, as we've seen capacity grow and grow and grow across the State.

You know, at this time last week, there was a lot of, I think, frustration and some negative press around our national statistics and where we stacked up against other States. And largely, that was around one particular metric, the percentage of doses administered. So, the number of doses you've administered out of the total doses that have come to Virginia.

And I just want to reassure everybody that that has really significantly improved over the last week. At some point for about 24 hours, we were at the bottom of that list, 50 out of 50 States, but we have steadily increased. We - as of the last time I checked earlier today, we were at 21.

And I think that number will continue to improve as we really focus, not only on the optimal delivery of vaccine, which we have been this entire time, but also on ensuring good data quality, ensuring rapid entry into VIIS. And I will say, being more focused with our vaccination strategy, you know.

Through the first five weeks of vaccination in the State, we had 840 different points where vaccine was going out to. And while in some ways that's good because you're increasing kind of the footprint of where people can access vaccine, from a data quality and data control standpoint, data accuracy standpoint, that is really challenging.

And so, as capacity has built up around the State to do much more efficient, much larger scale vaccination, I expect that we will continue to focus vaccine

on those vaccine channels that can do, you know, 1,000, 2,000 doses a day. This week, again, we were at about 105,000 new doses. We do expect that that number will increase.

And I think just yesterday, we received that we'll have the opportunity to do about 15 to 16% more doses for next week. So we're finalizing those numbers, but that is in line with what we've heard from the White House, and it's encouraging because it means we can get more people vaccinated.

Other big highlights. So we talked a little bit on Wednesday about the prioritization of long-term care facilities, right? You heard at the governor's press conference from members of our partners, CVS and Walgreens, and their willingness to accelerate their work and really make sure they work through the nursing homes and assisted living facilities and get all those first doses in by the end of January.

And then there are a group of facilities that kinds of falls out of what CVS and Walgreens were contracted to do. Some of the independent living facilities and the group homes for our intellectually disabled and developmentally disabled populations.

And so, as we now know how many of those are still out there, many health districts had been either vaccinating those communities themselves, or partnering with pharmacies to vaccinate those communities. But we now are ensuring that those communities as well are included in our long-term care facility strategy, and we have directly allocated a part of our State vaccine to make sure that those get done in the next two weeks or so.

And then about reallocation in general, you know, I think one of the ways that we are attempting to, you know, optimize the number of doses that go out is

by managing our first and second doses a little differently than we have in the past.

You know, up to this point, we've been drawing down certainly every first dose, and then we've also been drawing down all of the second doses that are available. One of the challenges of that strategy is that it has created a lot of second dose inventory for different providers that can't actually be delivered until people are ready for their second dose, until people have waited that full three or four weeks for their second dose.

And so, what we're doing this week and moving forward, is that we are still going to pull down every dose, but we are encouraging some providers to convert some of those second doses to first doses. And so, what that means is that we've just got to manage more effectively, the doses that we pull down and make sure that no one gets shorted in the coming weeks for second doses, but it does allow us to get more people vaccinated now.

And so, that strategy will allow us to get, you know, approximately 40,000 individuals get their first dose this week. And then as vaccine supply continues to increase moving forward, we'll be able to, you know, continue to employ that strategy. But really good news on all fronts.

I mean, I think that both the pace at which vaccination is happening, the capacity that continues to exist, and then the increase in vaccine coming to us this next week. I think, you know, probably the only piece of bad news is that it's not 100% increase because that's really - I mean, we really need and could handle significantly more vaccine at this point, given the infrastructure that's been built up around the State. So I'll pause there, see what questions you all have.

Melissa Gordon: Thank you, Dr. Avula. 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 the COVID-19 vaccine. For questions regarding other topics, 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. Operator.

Coordinator: Thank you. We would now like to open the phone lines for any questions. If anyone does have a question, please unmute your phone, hit Star 1, and record your name clearly when prompted. Again, that's Star 1 to ask a question. And if you would like to withdraw your question, you may use Star 2.

Our first question is from Sabrina Moreno with Richmond Times Dispatch. Your line is open.

Sabrina Moreno: Hi. Yes. Thank you so much for taking our questions. One of the ones that I had is, you know, communication and transparency between the federal government and the States has proven essential throughout this pandemic, but hasn't exactly existed throughout it or before it, which means a large variability in reporting.

So, how is the State working to address that, especially as we're trying to focus on race and ethnicity reporting and put equity at the forefront? But there's so much variability in kind of the - an inability to know where we really are at.

Dr. Danny Avula: Yes. Thanks, Sabrina. So, you know, we are posting that race and ethnicity data on our VDH dashboard. And what you'll immediately notice when you go to the demographics tab, is that there's a large number of folks that we don't have that data for.

Now, a few reasons for that, I mean, I think just because such a large portion of the vaccination that's happened to date, has happened in health systems to their own staff, some of the registration pathways they've used haven't, you know, taken the extra step to collect that data. And then that data doesn't get entered into VIIS, into the State database.

So, a couple of ways that we are approaching that. One, we're taking all of the data that has been entered, and we are cross-walking it with other State databases like DMB and the VLDS, and then able to pull in race and ethnicity data to close that gap.

That won't get us to 100%, but I think it will - you know, of the 350,000 or so folks who are not reported, we'll be able to probably cut that in half. And then moving forward, Dr. Oliver, State Health Commissioner, has - or is - has in the past already issued clinician letters, just reminding people of the importance of entering that race and ethnicity data. He's due to do that again next week.

And then there is currently a bill on the floor in the house that adds the requirement of entering that race and ethnicity data field for every vaccine that's administered, and the governor is very supportive of that. So I think we've moved towards a place where we're requiring that.

you know, there is a little bit of a catch 22 there, because if that is a required field and it keeps us from being able to count that number as an administered

vaccine, that creates more of a gap between doses administered and doses distributed.

But I think it's also an important stat because we need the information and we need to use the information to guide, you know, where we're doing vaccination events. Are we doing a good enough job of being accessible to Black and Brown communities that we know are at higher risk?

You know, while I think much of our vaccination effort over the next week or two will continue to be these large map vac sites, if they're not reaching our priority populations, then we've got to - you know, I've been in conversation this week with multiple faith leaders who have said, how can we help? Can we host vaccination efforts in our churches and our congregation, in our communities?

And my answer to them has been, you know, at some point, we will absolutely need that sort of distributed model, where we have more and more places that people can access vaccines.

In the near term, what congregations can do is help with things like transportation, and help identify members of their congregations or their communities that do meet the 65 and up or other essential worker priorities, and then help them get to our mass vaccinations.

And in that, coordinate with health departments to make sure that there's a certain number of blocks that are set aside for people of color, who we know are at higher risk. So I think, obviously closing the gap on the data, on the race and ethnicity data, will help us be clear, because right now, it looks very White.

And I think that's largely because of, when you look at the big groups of people who have been vaccinated to date, healthcare workers and, you know, the elderly living in long-term care facilities, those individuals skew towards the White population.

So yes, I think we are very aware of the need to have more clarity on that data, and we are, and we will use that data to create more partnership to get folks to these mass vaccination events.

Sabrina Moreno: Absolutely. And I just have a quick follow-up. You know, I know undocumented residents are eligible for the vaccine, but that some worry about privacy protections and having their names in a database, which has also happened with the expansion of driver's licenses. And I was wondering how the VDH is going to approach that and that other side of mistrust in vaccination.

Dr. Danny Avula: Sorry. Say that one more time? The inclusion of driver's licenses may keep the Hispanic population from being able to access? Is that what you're saying?

Sabrina Moreno: Oh, no. Sorry. I'll repeat that. So, undocumented residents, I know that they're eligible for the vaccine, but that some worry about privacy protections and having their names in a database when they sign up for a vaccine. And I was wondering, what is the VDH's approach to that - to kind of mitigating that mistrust, or if you've heard of anything, of any approaches moving forward?

Dr. Danny Avula: I got you. Yes. I mean, I don't think there's any way around the entry into a database. And so, I do think we're going to have to rely more heavily on the

community ambassador program that is being developed, and our community health workers in the different parts of the State that have that, to address the concerns and provide some degree of reassurance that they're not at higher risk.

And we've done that in the past, right? Like we do mass vaccination for flu every single year. And what we've seen when we've done that in predominantly Latino communities, is that just having somebody who is - you know, who has both language and cultural connection, can explain those things. And that has not served as a barrier for health department-run vaccinations historically.

So I think, you know, employing some of those same strategies, making sure that we have individuals onsite and in our call centers who both speak the language and understand the culture and can convey a sense of reassurance there.

Coordinator: Thank you. Our next question is from Brendan Ponton from WTKR-TV. Your line is open.

Brendan Ponton: Hello. Yes. I had a question about something you just talked about, Dr. Avula, in terms of second doses becoming first doses. I don't know if this is an obvious answer or a question maybe for someone in your field, but just, does anything have to happen to the actual dose in order for that to be possible, or what kind of steps need to be taken to do that?

Dr. Danny Avula: Yes. Thanks, Brendan. No. The doses are the same. The first doses and second chances are the same dose of vaccine. What does have to change is that we just have to manage that and track that, because when we convert

second doses to first doses, we need to make sure we're prepared to come behind that with two times that number.

So let's say you're a large provider. You have 1,000 doses that are labeled as second doses, and you convert those to first doses. Now, presumably those second doses that you had, were already reserved for 1,000 people who received first doses three or four weeks ago.

So you've got to replace those. So 1,000 doses to replace those second doses, but then, now that you've made those 1,000 doses - first doses for 1,000 new people, you also have to make sure that three to four weeks from now, you've got to have 1,000 more doses to come behind that.

So, for every dose you turn from a second to first, you need a 2x replacement, and that is going to require more active management on our part. So no changes to the doses themselves, just more active tracking and a different strategy for managing what we're pulling down.

Brendan Ponton: Yes. And I guess with that then, I mean, are you kind of banking on the fact that the allotment will continue to go up or, you know, just how do you make sure you don't run into a situation where, you know, you run out of second doses?

Dr. Danny Avula: Yes. So what we were able to do was set aside doses - 62,000 doses that had previously been a part of the long-term care pharmacy allocation. And so, that would provide some buffer. And then to some degree, we are banking on increased production and increased supply. But that 62,000 buffer, with the addition of increased supply, does give us the ability to do this.

And I only really think, Brendan, that this isn't going to need - this is going to

need to happen for the next three to four weeks, right? Because the reason we're in this situation is because the initial rollout over the first few weeks, just didn't happen immediately.

Like every dose that came into the health systems and other providers, weren't used that same week. And so, there was a little bit of a backlog that has led to now, you know, if you look at the data today, you see about 240,000 second doses that are in inventory around the State.

And we - as we really work through that over the next three weeks, then we'll be at a point of steady State, where for every new 105, or 110,000 doses that are coming into the State, those will all get used up every week. And then we'll just have the corresponding second doses behind that.

So, this active management strategy is really to address the buildup of inventory that was related to a slower rollout from the first few weeks.

Brendan Ponton: Okay. Thanks.

Coordinator: Thank you. Our next question is from Brett Hall with WAVY-TV 10. Your line is open.

Brett Hall: Real quick - before my question, real quick follow up to what Brendan said, actually. So the 105,000, is that all first doses or is that a mixture of first and second doses, the allotment per week?

Dr. Danny Avula: Yes, sure. So it's 105,000 first doses, and the second doses are allocated from the federal government above and beyond that. So last week, as an example, we had 105,000 new first doses, and then about 61,000 second doses.

So we do expect that that 61,000 or that - whatever the number of second doses, will continue to increase. In a call last week with General Perna, Secretary Carey did confirm that the federal government feels fully confident that all of the second doses will be accounted for, that there aren't any concerns about production.

And I think, you know, hopefully that's reassuring to providers who have not been moving their inventory, right? In some cases, we've had places that have been holding on to inventory because they weren't sure what they could count on from the federal government.

And so, they wanted to make sure that they had second doses in stock to cover their patients and staff that they provided the first dose to. So that has been an issue and that we have really, again, leaned on our providers and anyone who's been - who's had vaccine to say, hey, we're now three straight weeks where we've gotten every second dose that we - that had been reserved for us.

Production is good. There's high confidence at the federal government level that this will continue. And hopefully, that provides some degree of reassurance that people will just use their inventory moving forward.

Brett Hall: All right. And the other - I guess, I'll use my follow-up to, the question would be, switching gears, what are your thoughts on the news today about the Johnson & Johnson vaccine being 66% effective from your professional opinion on that?

Dr. Danny Avula: Sorry. Say it again. I didn't - I haven't actually seen the news.

Brett Hall: Oh, I'm sorry. Well, Johnson & Johnson, there was a report that came out that their vaccine is 66% effective with the one dose. And, well, I guess, if you haven't seen it, I don't want you to talk about it because I'm sure you want to talk more about it, but I can switch my follow-up to being the - when you have online the data that the vaccine going to municipalities, does that include the first and second doses?

Dr. Danny Avula: Yes, it does, and I don't remember if we've split that out, but the total doses that are going to each locality includes first and second doses.

Brett Hall: All right. Thank you.

Dr. Danny Avula: Yep.

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

Kate Masters: Hi. Thanks so much for doing this. My first question was sort of a technical question related to the data. When you go to the updated dashboard in the vaccines received tab, you know, you can see these different provider settings, and for medical practices, for example, that somehow they've received 13,350 doses, but then administered 50,906 doses.

That's the case for other community health providers as well. And I was just wondering if there's a reason why there are some - they're administering more doses than they appear to have received.

Dr. Danny Avula: Yes. So this is the redistribution issue, Kate. So early on, most of the vaccine went to hospitals. What we encouraged hospitals to do is, after they vaccinated their staff and saturated their 1a demand, we asked them to either

start vaccinating folks out in the community, or to other 1a providers who weren't affiliated with a health system, or to - if they didn't have the capacity to actually do the vaccination themselves, to transfer that vaccine somewhere else.

Now, the CDC tracking system did not really have a good way to account for this. And so, in many of these situations, you know, a health system would have provided, you know, 1,000 doses to a pharmacy, or 500 doses to a practice.

And so, there are many medical practices and other community health providers that have administered more doses than they've received, because the doses they've received, aren't accounted for until we go back and manually map where each of those distributions came from.

So that work is ongoing. If you've noticed from the time we rolled this out on Wednesday, that gap has continued to close because we have a team that is basically working with every health system, health department, and other providers who initially received a first disbursement of vaccine and saying, okay, where did you send it, and how do we track this back? And then we have to manually adjust the data.

Moving forward, we really are discouraging that kind of redistribution, because it makes it harder to track the data. And as we have more and more providers that have gone through the CDC approval process, you know, more and more people will get direct allocations.

But also, as I said, we're really trying to streamline it, right? Like we have so many places that can do large scale vaccination that is just more efficient and easier from a data control standpoint to prioritize those channels.

Kate Masters: Okay. That's helpful. And then I guess as my follow-up, so, you know, when you look at the data, it is clear that at least for the first three to four weeks of distribution in Virginia, hospitals have gotten a large share, you know, I'd say the majority share of doses that have come into State.

A lot of them have redistributed them to practices within their own system. So they're kind of still within that hospital system umbrella. And, you know, now, we've just seen reports from so many health systems that they're vaccinating staff who are not frontline, you know, and have been able to work from home for most of the pandemic.

There have been reports from multiple districts that staff are offering vaccines to patients within the health system. And to me, it just doesn't seem like a very good way to ensure equity, which I know is a big State priority in vaccine distribution. So, has there been any thought to telling hospital systems to not do that or exercise more oversight into how they are distributing these vaccines?

Dr. Danny Avula: The former, yes. The latter, no. I mean, I think it clearly was the intent to make sure that hospitals had what they needed to vaccinate their frontline healthcare workers. In some cases, that went beyond, and that was not our intent. Our intent was not to allow hospitals to, you know, have vaccine just for their frontline staff or for their patients for that matter, right?

So, you know, I would say most hospital systems absolutely got that message and have, you know, handled that really responsibly and then turned out and serve the community in really helpful ways. So, I think that the other part of this is that at the beginning of distribution with the Pfizer vaccine that

required ultra-cold storage, across the State, many hospitals and health departments have that capacity, but very few other providers did.

And so, that drove a lot more vaccine to those sites just because they have the ability to ensure cold storage. And so, yes, I mean, I think, to your question, we really want hospitals to continue to focus on our priority populations, and to do that in partnership with our health departments. And I would, say most places across the State, that is clearly happening.

Kate Masters: Okay. Thank you.

Coordinator: Thank you. Our next question comes from Andrew McClung from WCYB. Your line is open.

Andrew McClung: Hey, Dr. Avula, I just wanted to ask, how have the local pharmacies been helping? I know we have Food City down here in Southwest Virginia helping us. How much have they helped just in the vaccination process?

Dr. Danny Avula: Yes, Andrew, I appreciate the question. I mean, at this stage, pharmacies have definitely been a smaller part of the pie. You know, if you look at our total doses administered of 650,000 or, sorry, what is that number? Higher now. Six - I lost it.

But the pharmacies have done about 18,000 of those doses across the State. Why is that? I mean, so - and that - sorry, and that is above and beyond what the - what CVS and Walgreens are doing with long-term care, right? So, there's private pharmacies, like the one you mentioned, but outside of the long-term care partnership.

And I think it looks different in every district. Down in Southwest Virginia,

again, that sort of mass vaccination concept doesn't work great, because it's a massive geographic area to cover. And so, they do need a more distributed model.

And then there are many examples of pharmacies who have really come to the table and said, hey, we have relationships with these group homes, or we can help deliver vaccine at a high rate to this specific population. So, I think there are more and more of those partnerships emerging, Andrew, but they have not at this point, not because they don't want to.

There are 420 pharmacies who have gone through. They're approved vaccinators. They're absolutely ready to serve in whatever way is needed. But because we are really trying to be focused at the large-scale vaccination, especially in the population centers, pharmacies have had a smaller part of that pie.

But moving forward, you know, as we get more vaccine supply and we need that 50 plus thousand-dose a day target, we are absolutely going to need pharmacies of every kind. They've been amazing partners, and will - I think will continue to augment our capacity a great deal.

Andrew McClung: I guess, just a follow-up question I have for that is, how do you decide how many doses go to those pharmacies? I know a lot of people are just calling right now just because they get them within like five minutes and everybody sets an appointment just like that.

Dr. Danny Avula: Yes. So that strategy is determined by the local health districts in every area. So, you know, with such limited vaccine supply, so let's take that 105,000 number, what we have done over the last couple of weeks is done a per capita distribution.

So you just take the population of a locality, and we're actually aggregating by health district, and that's the share of vaccine they get. And so that number of vaccines is committed to the health district.

And what the health district has to do is, knowing its dual charge to vaccinate those who are 65 and over, and then work systematically through those essential worker tiers in group 1b, they figure out, what's the best way for us to do this for our community?

And so, in some places, that is, a certain amount is going to go into mass vaccination, and then another amount is going to go to our pharmacy partners who are going to do our 65 and up population. And in other places, it's a much more distributed model where a health department does very little, and most of goes out to, you know, federally qualified health centers and private providers and pharmacies to hit those different tiers. So there's not a one-size-fits-all answer. Different health districts have used pharmacy partners in different ways.

Coordinator: Thank you. Our next question comes from Mike Still from Kingsport Times-News. Your line is open.

Mike Still: Thank you. Dr. Avula, you and the governor in the last couple of weeks, have talked about the difficulty in dealing with rural areas, and specifically I'm dealing with the Lenowisco Health District. Do you all have some sort of plan in place to deal with clinics in a distributed area like that, mass clinics especially?

Dr. Danny Avula: Yes. I mean, again, so much of the local strategy is driven by the local health department in that area. And so, the Lenowisco Health District and the

Cumberland Plateau Health District, I mean, they are determining, how are we going to do this for our population?

Now, again, that - when you have such a limited pie to begin with, that means it's a pretty limited slice that comes out to every area. I mean, and not even just rural Virginia, but every area has far less than they need to meet the demand in their community.

So, what is the plan? It's to get vaccine distributed equitably to every local area, and to have the local health districts really work with their partners to drive that strategy. And, you know, I would actually say that in Southwest Virginia, at least per capita, their rates of vaccination are much higher than other parts of the State.

You know, I think those health districts and partners down there have done a phenomenal job of getting vaccine out very rapidly. So, yes, I mean, I think we're really constrained by supply, and until that changes, there's going to be a sense in every corner of the Commonwealth, that we don't have what we need.

Mike Still: Right. Just a quick follow-up on that. Once supplies start to approach something, you know, manageable and adequate, that's what I'm asking, what sort of plans - how are we going to handle mass vaccination distribution at that point?

Dr. Danny Avula: I got you. Yes. So, you know, I think largely, the mass vaccination concept doesn't work in a geography like that. And so, there may be one-offs where in different parts of Wise County or Russell or wherever, that there may be a place where like a one-time event makes sense.

But largely, it will go to that more distributed model where you have, you

know, folks like The Health Wagon, and the federally qualified health centers, and private provider groups, and pharmacies, who are all part of that strategy, when there's enough vaccine to feed all of those channels.

Mike Still: Right. And I'm sorry, I know I'm being a little pushy here, but one last follow-up. Specifically to Health Wagon, since they are having difficulty getting supplies as compared to hospitals and other providers, so basically the Ballard area and Lenowisco. Do you have non-profit health organizations that are also seeing difficulty in getting doses? Health Wagon ...

Dr. Danny Avula: Yes. I think there providers across the entire Commonwealth who are getting difficulty getting doses, right? Remember that right now, as we have such limited supply, it's going to go to the channels that can get it out in as large quantities as possible.

And I don't know all of the details of how that's being distributed down in that part of the State, but certainly, I've talked to free clinics and federally qualified health centers across the entire State, who are saying, hey, we can get to these vulnerable populations, and I have no doubt that they can.

I mean, I have worked with those incredible, incredible providers for a decade and have the utmost trust and respect that they absolutely can. But the fact remains that when you've got a small pie and you've got to be really - have really tight accountability around the data, that it's going to take more time to be able to get vaccine to those providers, and to make sure that they're ready to do everything they need to do to manage cold storage, to safely and effectively administer the vaccine, and then to get the data entered.

Mike Still: Okay. Thank you. Appreciate it.

Coordinator: Thank you. Our next question comes from Luanne Rife from The Roanoke Times. Your line is open.

Luanne Rife: Hi. Thank you so much for doing this. There's - our readers are just so very interested in all of this. And I had two questions. One is that on the dashboard now where you're showing, you know, quite a few first doses still being with hospitals. And I think in answer to Kate, you said some of those were redistributed. Do you have any idea how many first doses are still sitting with health systems that haven't actually been used?

Dr. Danny Avula: I don't yet, Luanne. I think that has been - the team that we onboarded last week, is kind of systematically working through each health system and each provider to figure out how to reconcile that. So I think - oh, and part of what we - you know, as - so we send out all of that data to the hospitals every week, and that helps close the gap. That helps motivate some data reconciliation when their numbers don't match ours.

So I think it'll take a few more days, but, you know, perhaps by the middle of next week, I'll have - and, you know, by our press briefing next week, I should have more clarity how many first doses are still out there.

Luanne Rife: Okay. So that's not clear yet. And then I had a question about this strategy of using second doses as first doses. And I apologize because this is going to sound like a real riddle, but I'm trying to figure it out. So if you give what was intended as a second dose as a first dose to someone, can you then - would you then be eligible for a second dose of that first dose, so that eventually you would be building up enough doses coming in?

Or would that second dose not count as the first dose in what you would get from the federal government? So then you might risk running out at some

point, and then have to decide whether people are going to get second doses on time?

Dr. Danny Avula: Right. So a second dose that we choose to convert to a first dose, we will not be able to, I don't know, convince the government that they should then assign a second dose to that. It's just not how they're allocating things right now. So we've got to manage that as a State.

And so, every second that we convert to a first, we need to make sure that we have, like I said, 2x to replace, you know. 1x to be the second doses that we're taking away, and that way, you know, the appointments that people have for second doses over the next two and three weeks, won't need to be changed at all. But then we also need to come up with the second doses that correspond to the seconds that are now first.

So the real answer is that we have to manage that internally. We - as I said, 62,000 of those doses are a buffer that we've created, by doses that had not yet been pulled down from the long-term care partnership. And then we will see more and more production each week, which allows us to continue to build that buffer and make sure we have what we need.

And then again, as I said, this is really only a three to four week exercise, because we will very quickly get through our inventory, and get to a point where we're using every first dose that comes in. And then the second doses will come in on the same schedule, and everybody will just be reassured and trust that they're going to get their second doses and will stop holding on to them.

Luanne Rife: Okay. So that is all really contingent on the supply of vaccine increasing?

Dr. Danny Avula: Correct. No. At this point, so for example, the 40,000 or so doses that we asked health systems to actually use as first doses this week, they don't need all 40,000 of those doses next week. And so, because of the timeline in which they administered doses in weeks one, two, and three of vaccine delivery, they have inventory that can't be used for the next two or three weeks.

And so, they're going to - so let's just take a hypothetical example. Some health systems uses 10,000 doses this week. They only have 3,000 appointments, second dose appointments, next week. And so, we can refill that 10,000 over the course of two or three weeks.

So we will - I mean, supply is getting better. We know that based on the new allocation number we just got last night. And I don't know if that will continue to increase every single week, or if we'll just have to bank on that 16%. But yes, I think the combination of the doses that we have reallocated from LTCFs, and the increased production, will be able to cover us clearly for the next three weeks.

Luanne Rife: Okay. I was just concerned about going forward, you know, after those initial three to four weeks, that if the supplies don't increase coming in, I'm guessing you're really assured that there's going to be an increase in the number of doses available to Virginia.

Dr. Danny Avula: Yes. So, I mean, let's just take the 40,000 that we authorized this week, right. So I need a 2x replacement on that 40,000. And so, between the 62,000 and the about 18,000 new doses that are coming in next week, that's my buffer, right?

So just to kind of make it super concrete, it will be managed a little bit more actively, because the truth is, I don't need 80,000 next week, but I know it's

there. And this whole strategy of moving seconds to first, isn't something that we're going to be doing every week. It's just something that we're going to be doing while we know we can replace it, and while we need to burn down existing inventory.

Luanne Rife: Okay. I see. Thank you.

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

Jill Palermo: Hi, Dr. Avula. Thank you so much for taking the time to do this today. I joined the call a tiny bit late, so I didn't hear if you had said that we will be getting our extra 16% - how quickly we'll be getting the extra 16% of doses, and what that number will be. That's my first question.

Dr. Danny Avula: Yes, so it's coming next week. We were told last night that our allocation for next week will increase by about 18,000 doses. That will immediately translate to 18% more per locality because of this - you know, making sure that we have the buffer to cover second doses that are used for first basis.

So we're still working that out. There should be a slight increase for all localities, but it won't be a perfect like 16% increase for every single locality.

Jill Palermo: Okay. So we're going from between 105 and 110 to 18,000 more than that going forward for the foreseeable future?

Dr. Danny Avula: Yes.

Jill Palermo: Is that correct? Okay. And then I - go ahead.

Dr. Danny Avula: And I'll say one more thing about how we're choosing to allocate that. So for example, you know, at the top of the call, I mentioned that we had recognized that there's some long-term care facilities that were - yes, that just, we need to ramp up the schedule to make sure that they're getting vaccinated in the next couple of weeks.

And so, you know, some of that - some of the vaccine coming into the State, will be set aside to make sure we get those 1a populations done across the Commonwealth.

Jill Palermo: Okay. And then I have a question about our specific locality. I noticed that Prince William is quite behind in terms of, you know, rate of vaccine administered per capita. We're behind our other, you know, localities in Northern Virginia.

And I don't know if you can shed any light on why that is. So we're at 49 - 4,934 per 100,000. Whereas like Fairfax, for example, is at more than 7,000 and Loudoun is at more than 6,000.

Dr. Danny Avula: I don't know. I mean, I'll - yes. I don't know the specifics of principal in situation. I do think that some of the reasons we see that kind of variability around the State, is kind of what has gone to health systems, because so much of the vaccine at the beginning of this did go to health systems.

And so, the larger health systems, both vaccinated high rates of their staff, who often live in the county, but also then pivoted and did a lot of other providers and other 1a and now 1b populations in that area. And so, I would have to do a deeper dive, and (Dr. Ansari) could probably certainly shed some light on that. But that would be one reason, you know, just the degree to which health systems have pivoted their vaccine for residence use.

Jill Palermo: Okay, great. Thank you so much.

Coordinator: Thank you. Our next question comes from Ian Munro from Daily News-Record. Your line is open.

Ian Munro: Hi, good afternoon. Building off Kate's question earlier, we are in an area where the local health system, Sentara, is prioritizing its own patients over members of the public. I spoke with a representative yesterday, one of the doctors, and he said that their rationale is, with such a low number of vaccines available, they had to come up with something to narrow down who was available.

Does Virginia Department of Health believe that, you know, setting up that, you know, I guess, priority to eligible folks, you know, who see Sentara primary care providers over other eligible members of the public, do they see that as a valid rationale?

And part of this question too involves the hospital system itself. Sentara RMH has been losing providers due to workplace conditions in the area, driving many folks to pursue primary care doctors north at Valley Health and south at Augusta Health. So that's just an important background on the situation.

Dr. Danny Avula: Got it. You know, again, our intent was to make sure that health systems had what they needed for their staff, right? That's why a lot of health systems receive vaccine in large amounts. And then the other side of that was the practicality of them having the ability to ensure cold storage.

Our hope is that health systems would partner with health departments and

really think about the population at large. And so, in some cases, that means a health system is a really important provider of care to vulnerable populations. And so, you know, without - I mean, I really do think that the places where health districts and - so the public health infrastructure and health systems are joined, and are strategizing together about how to get to these different tiers of the community.

Like, that's the way it should work. And I'm not sure - you know, I think that varies. I mean, even with Sentara to be specific, like that probably varies from county to county because Sentara has such a large footprint. And so, yes, I don't know how to give a more entailed answer about a local situation, not knowing what that partnership looks like.

Ian Munro: I understand. And well, the follow-up to that too is, I mean, how was this kind of system allowed? I know that, you know, what - slash, what can VDH do about this? I mean, I heard you say you hope that something can change. Is there anything that VDH can actually do to change Sentara's policy of prioritizing its primary care patients who are eligible over members of the public who are eligible? Because I've heard stories of 80-plus year old people being turned away.

Dr. Danny Avula: Wow. Yes. I have not explored that route. I think Kate asked a similar question. It's like, have we looked at what we can do to - for certain providers' hands? And we haven't. You know, I think the approach really has been, how do we partner together? How do we drive vaccine together?

I mean, I think what we can, you know, this is part of why the allocation strategy runs through the health districts now, is that the health district can work with providers to really ensure that, you know, those priority groups are priority groups, that they actually get prioritized.

So, you know, I mean, I guess there's probably a legal, or, you know, some sort of policy pathway to force their hands. We just have not explored it because again, in most places, it's worked really well and there hasn't been a need for it.

Ian Munro: And I'm sorry to - again, just one more follow up too. I mean, one of the things that they announced when they said they're prioritizing, when it became clear that they're going to continue prioritizing their own patients, was also that they are vaccinating all Sentara staff.

And the rationale they gave me for that was, well, Sentara staff falls under 1a, but I looked on the website, the VDH website about who falls into 1a. I did not see that, you know, for example, office staff at Sentara would fall into 1a. And it is my understanding that Sentara staff, and outside of 1a, because they are not included on the list online, are being vaccinated.

Is that a problem or are they correct in saying all Sentara staff, including office workers who may be remote, have access to the vaccine over other people in 1a or 1b?

Dr. Danny Avula: Yes, the - I mean, the intent and the definition of 1a really is healthcare personnel who were at higher risk because of potential exposure. Now, sometimes there are office staff because of where they work in a clinic setting, or because of potential, you know, patient contacts who would clearly qualify. It's not just doctors and nurses. It's dietary staff. It's custodial staff.

So, I think there are many categories of non-licensed healthcare providers that would qualify as 1a, but the hope and intent was that the healthcare systems

would prioritize those who are actually at increased risk because of exposure to patients.

Ian Munro: Okay, yes. All right. Well, thanks very much, doctor.

Coordinator: Thank you. Our next question is from Brendan King from CBS 6 Richmond. Your line is open.

Brendan King: Hey, Dr. Avula, thank you for your time. I appreciate it. It's good to hear from you. The journalists on this call have answered a lot of my other questions, but I do want to ask, we know it'll take months for everyone who wants a vaccine to have access with one. So with the news of those new COVID variants out there, would you recommend that Virginians double mask?

Dr. Danny Avula: Huh, thanks for the question, Brendan. You know, I think that the CDC has pretty clear and helpful guidance around what masks are effective and what masks aren't. As I've looked into the double maxing trends that I've seen, you know, I think that two masks probably do sometimes, you know, have a tighter seal or provide a double barrier. And I think it's fine.

Like, I think it's a fine thing for people to either wear double masks. I don't know that we have enough like actual data to make a recommendation of, does that definitively protect you more than a single mask? So, I certainly wouldn't discourage it, but I don't know that we would come out with a policy statement until there's more data.

Brendan King: Thank you. Appreciate it.

Coordinator: Thank you. Our next question is from A.J. Nwoko from NBC 12 Richmond. Your line is open.

A.J. Nwoko: Thank you. Dr. Avula, with the expected increase of vaccine doses coming to Virginia, are we going to see an increased store or an expedited timeline of when we'll have 1a and 1b groups completely vaccinated? And if so, with this new increase, when can later groups be added, or when can other people who are a little bit further down the line, expect to get a shot in the arm?

Dr. Danny Avula: So, A.J., 16%, you know, is again - any increase is welcome, but it's still not enough to significantly change the timeline. I think that it probably, you know, increases our rate of getting through all of 1a and 1b by a couple of weeks at best.

But we're still talking - you know, unless we see this as a sustained 16%, right, like the 16% over what we're getting each week, I don't think that was what the White House communicated, or something changes rapidly in terms of, you know, either AstraZeneca or Johnson & Johnson coming on board. I think we're still looking at, you know, late March-ish probably to work through all of 1b.

A.J. Nwoko: All righty. And then for my second question, there are instances where vaccine doses that were allotted to pharmacies that were supposed to go to long-term care facilities and the like, were having to put those doses on hold as those long-term care facilities dealt with outbreaks and things of that nature.

Have there been any attempts to free up some of the vaccine supply that is being tied up with pharmacy, their long-term care facilities, to get those vaccines to different areas of Virginia and different people who need them?

Dr. Danny Avula: Not exactly. I mean, I think CVS and Walgreens, who are doing those facilities, have pulled down a fair amount of vaccine, right? I think at this point, they've had 160,000 or so doses that have been set aside for them. So they're continuing to work through it.

I mean, I think those things are unexpected, right? And so, they pull down what they need to work through. If somebody's having an active outbreak, they may need to put that off for two to three weeks. But, you know, it's - there's enough other inventory out there that I really just want CVS and Walgreens to have what they need, to not have to worry about, you know, not having the supply and to get through that community. Again, those are - that's the top of our list, and we need to make sure our long-term care folks are finished as quickly as possible.

Melissa Gordon: Hello, everyone. This is our five-minute warning before we end the call. We have time for one final question.

Coordinator: Absolutely. Our last question comes from Brandi King from (Novenza) in Salem. Your line is open.

Brandi King: Yes. This is somewhat related to the last question, but the local health districts requested that one point of contact for manufacturing companies that have frontline workers, submit a spreadsheet for those that are willing to get vaccinated. Do you know when you - or when do you expect to start those vaccinations for those manufacturers that were definitely considered to be essential from the beginning?

Dr. Danny Avula: Yes, I think that that is going to vary a little bit from district to district. Manufacturing, if I remember correctly, I think was like the fourth or fifth tier

in 1b. And what I've been telling - as folks have been reaching out to the State, wondering, you know, where does - where do we fall? We're in 1b.

I think it's going to be a month or longer before we get to the fourth or fifth tier of 1b. And so, I'm trying my best to help people manage their expectations. You know, they are still in 1b, but given vaccine supply, it doesn't mean that they're going to get vaccinated tomorrow.

So yes, realistically, I would say early March, but I don't know the demographics or the demand in that part of the State enough to know, will it move faster than that?

Brandi King: Yes. And I appreciate them planning and asking for a count. Do you have an idea of whether they're going to ask our employees to go to these max vaccination sites, like you mentioned, where you can have limited vaccination sites? Or do you think they will ask the manufacturers in the community to step up and come to our sites to do the vaccinations?

Dr. Danny Avula: Again, it depends on capacity. So if a manufacturing site has 1,000 employees and has their own occupational health capacity to do their own vaccinations, then it would be just - it would be efficient to just know who's going to get vaccinated and send over that much vaccine.

So, you know, I think the logistics of that will vary. If it's a smaller manufacturing outfit and the health district is holding a closed POD for multiple organizations, then they may have that done as a more central operation where they invite you to come to that. But you'd really have to talk to the local health director who is planning all of that.

Brandi King: Yes. Great. I appreciate it. Thank you, and thank you for what you do.

Dr. Danny Avula: Thank you.

Melissa Gordon: I want to thank everybody for joining our call today. There will be an audio recording posted on the VDH website, as well as the written transcript. You'll be able to access these documents at vdh.virginia.gov/coronavirus/media-room. Once again, if we were unable to answer your question today, please email them to the VDH communications office. Thank you.

Coordinator: Thank you all for participating in today's conference. You may disconnect your line, and enjoy the rest of your day.

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