

**Virginia Department of Health Tele-Press Conference on  
Virginia's COVID-19 Vaccine Developments  
Moderator: Melissa Gordon  
March 12, 2021, 3:00 pm**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode until the question and answer session of today's conference.

At that time you may press star 1 on your phone to ask a question. I would like to inform all parties that 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 am 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. Good afternoon, everybody. To start with, where we are today, 2-1/2 million doses administered, 19-1/2% of our population. And if

you look at our weekly output of 70 moving averages, almost 55,000 doses a day.

So we're in a really good place as far as looking at the pace at which we are vaccinating Virginia as we look forward to the opportunity to get through our 1B and really start to open up into 1C and the general population. That feels right around the corner.

In relation to some of our neighboring states, we are ranked today fourth in the country in terms of the percentage of doses administered. So that efficiency rating, our ability to get vaccine out as soon as we get it is really, really impressive.

I just can't thank all of our health departments and health systems and providers and pharmacies enough for the pace at which they've been setting up large scale and small scale clinics across the state.

We are 12th in the country for the percentage of people fully vaccinated, which puts us right - the number of people fully vaccinated which puts us right in line. We are the 12th most populous state.

So, you know, as we think about where we are now with allocations, this upcoming week we anticipate a total of 195,000 first doses of Moderna and Pfizer, about 167,000 second doses of Moderna and Pfizer.

And then as anticipated, we didn't get any Johnson & Johnson this week. And we just found out yesterday that next week it will be a small amount of Johnson & Johnson, 9,600 doses.

We expect that that will be a similar number the following week. And then again, the week of March 29, we really expect to see the Johnson & Johnson allocation shoot up to potentially north of 100,000 new doses.

So the month of April and May are really going to be our highest supply totals and our highest outputs and really where I think we can make significant progress on getting our state vaccinated.

Given those projections, I think it is very realistic that we will get through our 1B demand by mid-April. In some parts of the state that's going to be sooner. And so we really are going to allow different parts of the state - much like we did with the 1A to 1B transition, different parts of the state will move to 1C and to 2 at their own pace depending on, you know, the unique demographics of each of their communities. We certainly don't want to slow any vaccination down.

And I would say that the most significant difference, compared to where we were with the 1A to 1B transition, is that we're just in a completely different supply environment. And so it will allow us to really get vaccine to every part of the state and to keep it moving very quickly. The best way to do that is to allow that flexibility.

In addition you heard the President the other day say, and maybe yesterday say, that he would like every American to be eligible for vaccination by May 1.

And as we look at the supply and the pace and the demand here in Virginia, we really think we will easily meet that May 1 marker and potentially even outpace it by a couple of weeks.

As I said, I think if we get through 1B in mid-April, 1C will be a pretty short period of time, both in terms of anticipated numbers and the fact that 1Cs are going to start to filter in before that.

So, yes, I think everybody who wants a vaccine will be eligible. We'll move into that open eligibility before the end of April and everybody who wants a vaccine should be able to be vaccinated by the end of May, at least with the first dose.

The Johnson & Johnson rollout this past week has been a great success. We received last week 69,000 doses of the Johnson & Johnson. All of that was directed towards mass vaccination events all over the state by Health Departments and health systems.

A really great turnout for those. I think in my conversations with the various leaders running those events, very little difficulty - really no difficulty filling the appointments and really positive affirmations about the Johnson & Johnson vaccine in ways that maybe we didn't anticipate.

You know, I think a lot of the comments we received is that I'd rather have one dose than two. And so to be fully protected with just that first dose has been a real attraction for many, many residents.

So, you know, with these 9,600 doses we will - you know, we'll still do some larger events, but I think we've really established uptake across, you know, many geographies and many age and race demographics and feel really good about the uptake and the consistency of messaging.

And so we'll continue to use Johnson & Johnson in lots of different ways, all the while just really prioritizing transparency and ensuring that people know that they have a choice.

And, you know, while they may not be able to go to an event and pick and choose a vaccine at that specific event, they will always know what type of vaccine is being given at an event.

And then maybe the last thing I will talk about briefly is the CVCs, these community vaccination centers that are starting next week. You know, this has been a part of the plan since the very beginning.

I've talked often about the five channels which will deliver vaccines, health departments, health systems, providers and pharmacies and then the fifth channel of larger vaccination sites.

But they really have not made sense from a supply standpoint until now. And now that we're starting to see that supply come in, we can seed these channels with 1,000, 2,000, 3,000 doses a day.

We are rolling these out. And they come right in time for the expected surge of April and May where I think we will, like I said, supply north of 600 - somewhere between 600,000 and 700,000 total doses per week.

Our three sites are going to be in Danville, Portsmouth and Petersburg. And the Danville site will start on Monday. The Portsmouth site will start on Tuesday. The Petersburg site will start on Wednesday.

It's very important to understand that these sites are not open pods. That we are still working off of our pre-registration list because as we are in 1B, we

want to ensure that we are giving priority to any 1As who have decided that they now want to get vaccinated and then everybody who is eligible in 1B. But as I said, we are very close to getting near the end of that 1B list.

So in these initial stages, they will be closed pods. There will be appointments based on the preregistration system. And as we fill those appointments up and work through 1B and then open up, then we will shift our strategy to fill those appointments for as long as we need them.

Okay. Let's open it up for questions.

Melissa Gordon: Thank you for that update, Dr. Avula. Before we begin the question and answer portion of today's call, I'd like to remind everyone that 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](http://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 will begin the question and answer portion of today's call. Operator?

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press star 1, unmute your phone and record your name clearly. If you need to withdraw your question, press star 2.

Again, to ask a question, please press star 1. Our first question comes from Kate Andrews from VA Business magazine.

Kate Andrews: Hello. Thanks again, Dr. Avula. So President Biden's announcement asking states to make everybody eligible or all adults eligible by May 1, how is that different from the shift to 1B back in January which, you know, caused some difficulties?

You know, is it just purely down to the number of vaccine doses available or are there some other factors that make this kind of the smarter move it sounds like you think?

Dr. Danny Avula: Yes. Thanks, Kate. I think it has everything to do with both vaccine supply and the capacity to get it out, right?

When we made the transition from 1A to 1B, we were getting about 100,000 first doses a week and, you know, somewhere between 10,000 and 15,000 doses a day that we were ramped up, especially the beginning part of January.

Now we are averaging 55,000 doses a day and have shown the ability to get north of 70,000 doses a day. And as the supply keeps coming in, I have total confidence in the ability of those five channels to ramp up and sustain 70 plus thousand doses a day.

And so that reality, the fact that there's so many more doses available and so many more channels to receive vaccines through means that we're not going to have that really stark supply demand mismatch that we had when we went from 1A to 1B.

Kate Andrews: As a follow-up, it seems like there are going to be more, that there are more people who are under 65 now and just anecdotally are getting calls and emails about getting their shots.

Is that across the state or are there particular areas that that's more common?

Dr. Danny Avula: No. I think most of the state is finding that their 65 and up uptick is slowing. You know, the data obviously differs depending on the part of the state. But in an effort to not slow down the output of vaccination, you know, we've opened up to 16 to 64. And, remember, that has been the case since the initial move to 1B.

It was really about the allocation, right? So when we first moved into 1B, about 50% of each District's allocation was being targeted at the 65 and up population and then about 50% was going to the essential workers with the inclusion of 16 to 64 with underlying conditions.

As we worked through the 65 and up, more and more of that has been made available for the 16 to 64 with underlying conditions. So I think that theme has been consistent and obviously now that we're getting towards the end of that high risk 65 and up population, more and more is being made available for the 16 to 64 with underlying conditions.

Kate Andrews: Great. Thank you.

Coordinator: Our next question comes from Carol Vaughn from Eastern Shore Post.

Carol Vaughn: Hi. Thanks for taking my question. Looking ahead, which doesn't sound too far in the future now, since children cannot yet be vaccinated and there will be some adults that will not choose to, is it expected that we'll have enough to reach herd immunity or is it expected we're going to need to incorporate these protective measures into our lives on an ongoing basis?



You know, people are talking about getting back to normal. Are masks and distancing and handwashing going to be part of that new normal?

Dr. Danny Avula: Yes. Thanks, Carol. You know, I can't totally see the future. But I do think that 75%, while - you know, our aspirational goal is absolutely within reach. You know, as the national survey shows, about 65% of adults are, you know, ready and willing to get a vaccine.

I do think it is going to slow down and be a little more difficult to get that last tenth. But I also think it is highly possible as we shift more vaccine to private providers. I think people do really rely on their doctors and nurses for guidance and advice.

So as more of that vaccine ships out to provider communities, being able to take time and work through vaccine hesitancy will really increase uptick.

We've seen the national data shift in particularly Black and Hispanic populations. From December to February, their vaccine hesitancy has really dropped.

And so I think it really is within reach that we get to 75%, which is our target for herd immunity and then that will only increase when we start to vaccinate children.

You know, right now the estimates are that at least for the 12 and up population, that that could happen sometime later in the fall. And then Moderna and Pfizer are just now starting to recruit for age groups younger than 12. It is unlikely that we will be able to have an approved vaccine until first quarter of 2022.

Carol Vaughn: And as a follow-up - thank you. Any idea of - I see the clinical trials for children are starting to go on. Is there any estimate of when that will be completed? Have you all heard anything?

Yes. So Pfizer and Moderna right now are conducting trials for ages 12 to 15 and those will likely be wrapped up sometime in the fall. And so I think it is possible that, you know, perhaps around October or November we could have an approved vaccine down to age 12.

The younger age groups, they are starting to recruit for now. I think Pfizer is recruiting down to age 5 and Moderna is recruiting down to 6 months. That is going to be a slower process. I mean, these are much smaller numbers.

The way they are approaching these trials, I think I read this week it is about 3,000 people in each cohort. When you compare that to, you know, the initial trials of Pfizer that were 36,000 and Moderna that were 44,000, these are smaller trials that will be done at a slower pace.

So I really don't think it will be until likely late winter/early spring of 2022 if we have an approved vaccine for younger children.

Carol Vaughn: And simultaneously, as I understand it, they're developing- you know, looking at the mutating strains, the variants, is there any - should people be planning on getting an annual booster or do we not know that yet?

Dr. Danny Avula: Yes. We don't know the answer to that yet. I think we have seen good data that shows strong effectiveness of the Moderna and Pfizer and Johnson & Johnson vaccine in the context of variants and in particular the UK variants, the 117 variant.

Right now in the United States, that accounts for 20% of our circulating viruses. And, you know, our modelers down at the CDC do anticipate that by the end of March or beginning of April that will be the predominant strain.

It has moved very quickly in other countries. In Israel, as an example, from the time they saw their first B117 variant to two months later, it was 70% to 80% of their circulating virus. So thankfully our vaccines, you know, have been tested around the world.

We do have data that shows they are still very effective against the B117 variant. We are still awaiting data on the South African variant, the B1351 and then the P1 variant out of Argentina. So I don't know enough about that yet.

I do know that Moderna has started formulation of a booster dose that incorporates these predominant strains.

And I do think it's possible and maybe even likely that similar to the way that the flu vaccine is reconstituted every year, right, the strain of the flu changes every year, the circulating types of flu change every year and we have a new formulation every year, I do think it's possible we will have a booster dose that incorporates some of the newer strains moving forward that we take every year.

Carol Vaughn: Thank you so much.

Coordinator: Our next question comes from Cameron Thompson from WTVR CBS 6.

Cameron Thompson: Hi, Dr. Avula. Thanks, again, for the time. What can you tell us from the VDH's perspective about what happened at the Midlothian Kroger where they administered those empty shots to some people?

The company hasn't said yet how exactly this happened. Is VDH investigating this and has something like this happened elsewhere?

Dr. Danny Avula: I have not heard of any other incidents like this, Cam. And I really - I mean, I read the news reports and heard about the event. I don't know how that actually happened on the ground.

I don't think that Stephanie has joined us today. Dr. Wheawill is our state pharmacist. I know she has been dealing directly with the pharmacists.

What I do understand is that it was thankfully a thing that didn't lead to any harm as it was empty vials that were administered and it affected 10 or less people.

So thankfully no significantly negative outcome. But I don't know how that happened. I'm not sure if they received vials that just didn't have any vaccine in it or what happened there. So I'll get back to you when we have more information.

Cameron Thompson: All right. Thank you.

Coordinator: Our next question comes from Elisha Sauers from Virginia Pilot.

Elisha Sauers: Hi, Dr. Avula. Can you hear me okay?

Dr. Danny Avula: Yes. Hey, Elisha.

Elisha Sauers: Hey. I was hoping maybe you could just give a little bit more information about the mass vaccination sites that are partnered with FEMA.

I know you've already talked about them a little bit. But I was hoping maybe you could talk about the locations of them, how long they're going to last, what vaccine they're actually going to be using and if you could also just sort of elaborate on how those cities were selected?

Dr. Danny Avula: Sure. So three sites. We'll start with the Danville site is at the JCPenney. I guess it's an empty department store. And they've actually - the Health Department and City of Danville have been doing mass events out of that site.

Apparently it's large enough that they could actually accommodate both at the time. You know, they'll use the lower floor to finish up some of the second doses, use the upper floor to start the community vaccination center.

I am pretty certain that the Danville site will start with Moderna vaccine. And that will be 3,000 - I'm sorry, 1,000 people a day. Actually let me double-check that real quick. And that will start on Monday. That's 3,000 appointments a day.

The Portsmouth site will be at the Sports Plex. That will be 1,000 doses a day. And the Petersburg site will be at Virginia State, which will be 3,000 doses a day and that will start on Wednesday next week.

How were the sites chosen? We identified areas that had in general lower rates of vaccination and overlaid that with the communities that have higher rates of individuals who are 65 and up, individuals who are Black and Hispanic, Latino and then communities that had been hit harder by hospitalization and death.

And so kind of looking at the intersection of those lower vaccination rates and higher need, that's where we really started our analysis and our conversations with local health departments and local governments. And so these three were kind of the ones that were - where those conversations came to fruition the quickest.

How long will we be at the sites? I think it really depends on uptake and reach, you know, beyond that specific area. You know, I think some of these are doing daily vaccination at a volume that we really could saturate the area in two to three weeks.

And if they continue to draw from a larger geographic footprint, great. We'll keep them there. But if not, as we start to see appointments start to drop off and as we analyze that the footprint of vaccinators in that community, through providers, through their health department, through any hospitals and health systems can continue to meet the needs, then we would take those resources and move them elsewhere.

So this will be a pretty - you know, I would imagine we would be at least two weeks if not longer in each of these locations. But we will absolutely monitor their use and vaccine uptick in those communities and redeploy resources to other parts of the state if needed.

Elisha Sauers: And are Portsmouth and Petersburg also going to be using Moderna?

Dr. Danny Avula: Yes. I will need to get back to you on that. I think it's either Moderna or Pfizer. We didn't have - you know, based on the Johnson & Johnson allocations, I know it's not the J&J vaccine because we just don't have enough to seed those until probably the week of March 29.

I do anticipate that as CVCs pop up in other parts of the state, the Johnson & Johnson vaccine will be used through those events.

And once you start a site, you're also not committed to one type of vaccine. And so there may be phases where as the Johnson & Johnson vaccine becomes more plentiful in the month of April that some of those existing sites would become J&J sites as well.

Elisha Sauers: But the people who are invited to schedule an appointment through those mass vaccinations clinics, they are informed before they go which vaccine they are getting, correct?

Dr. Danny Avula: That's exactly right. And actually I just double-checked. So both of the other sites are Pfizer sites so the Port Smith and VSU sites are Pfizer sites.

And we have adopted a naming convention for all of our sites where we say specifically, you know, what group is being targeted or what group is eligible for appointments, what type of vaccine is being given and then, you know, obviously if it's a Moderna or Pfizer, when the second dose is going to be given.

So we really have been committed to making sure that people know that on the front end and then can choose to accept that appointment or not.

Elisha Sauers: Thank you.

Coordinator: Our next question comes from Brett Hall from WAVY-TV 10.

Brett Hall: Good afternoon, Dr. Avula. How are you?

Dr. Danny Avula: Hi, Brett.

Brett Hall: A question about - - hey -- how people that are on the 65 and older priority group, if they are still not hearing anything, haven't heard anything, by what time period, should they call, do anything?

We got an email today from two people, actually, to our newsroom about people over the age of 85 that have been signed up with the preregistration list and still have not heard anything.

They're hearing that 65 and older is going to be winding soon. What should they do?

Dr. Danny Avula: Well I think first of all when we say winding down, we will never stop eligibility for that category, right? So if somebody was 80 years old. They weren't sure they wanted to get vaccinated and they decide later, they will absolutely still be eligible and be able to get vaccinated. So I don't want anyone to feel like the window is closing at all.

We do want people to update their information. So about a week ago, maybe longer, there was an email blast that went out to everybody who was in the state preregistration system asking people to go in and update their information.

So it's possible that perhaps they, you know, spelled an email address wrong or didn't provide a phone number or just need to kind of update their date of birth information because we did have a lot of incomplete records that got merged into the state preregistration system.



Another reminder on this will be going out tomorrow. And I think the other option is people are not hearing, and I would certainly say this for, you know, the couple of examples that you brought up there, Brett, that they should call 1-877-VAX-IN-VA and have somebody try to help look their record up and maybe help them with the update.

Because, yes, I guess and really in most parts of the state, we're pretty deep into those 65 and up lists. So, yes, I would encourage them to call the number or go online and check their registration.

And I would imagine we will be through most of the preregistered 65 and ups we have, if their information is correct, we'll be through that in the next couple of weeks.

Brett Hall: And for moving to 1C, what is the threshold? I think another reporter on this call alluded to 1B, you know, a lot of cities became frustrated because they didn't exactly understand why, looking at the data, they weren't in 1B at first because the dashboard doesn't exactly show, you know, how many people per municipality or health district is in each phase.

So what's the threshold that the state is looking at to give a go ahead to move to a next phase?

Dr. Danny Avula: Yes. Because of our VIIS database, we're not able to pull data by occupation. What our health departments and other providers are doing is really just working off of that preregistration database by category.

And so they're really working through that list and then we're getting word out through every channel we can think of to let the 1Bs who are eligible know that it's time to get vaccinated.

So based on that approach, what will happen is as appointments start to not get filled out, you know, if you have multiple days where you drop below about 90% of your appointments going to 1B eligible, then that would be a sign that maybe your community is ready to open up to 1C.

Now what people are doing even now they're not allowing those appointments to go to waste. They're calling down wait lists with the next eligible tier. So let's say you have a 65 and up event and you slated it for 2,000 people.

If you are nearing the start of that event and see that you only have 1,500 65 and ups who have populated that event, then you're going to go to the next tier of eligibility, so you're going to open up to your 16 to 64s with underlying conditions so that you can fill out the rest of those appointments.

So, you know, we're really committed every week to making sure that every appointment is filled and we get these vaccines out.

Similarly, as we get closer and closer to the end of 1B, they will start using 1C as their backup list. And so if they have multiple days where they're having to go, you know, 10% or more into their 1C backup list, that's a good marker that you, as a community, are ready to go to 1C.

Brett Hall: All right. Thank you very much.

Coordinator: Our next question comes from Christina Thompson from WSET.

Christina Thompson: Hey. Thank you. So my question is a little bit more about just COVID protocol still. So we have a hospital system here that is requiring masks instead of face shields.

So I was wondering what's the difference between face shields and masks and is one safer than the other?

Dr. Danny Avula: Yes. Thanks, Christina. So masks have always been the mainstay, right?

There's not ever any situation where face shields were an acceptable alternative to masks. Because of the way the virus is transmitted, really ensuring that your nose and mouth are covered is the primary protective measure.

Now face shields in hospital settings were also encouraged particularly for health care providers that were engaging in what are called aerosol generating procedures.

So, you know, if you're a respiratory therapist who is doing nebulized treatments on a patient or you're intubating individuals or, you know, you're just providing close enough care and contact that you could get coughed on, you know, most hospitals, in addition to an N95 mask for a health care provider, were also recommending eye protection.

So I don't know the details of your hospital or your situation, but those are the CDC recommendations. I imagine, you know, most hospitals are going to be in line with requiring masks at a minimum and then encouraging face shield use as well.

Christina Thompson: Okay. Cool. So then if a patient has an underlying health condition like a lung condition where they can't wear a mask or it's hard for them to wear a mask, what would your recommendation be?

Dr. Danny Avula: You know, I guess a face shield is better than nothing but it's not really going to help you that much, right? The face shield really prevents the - I mean, I guess it serves as a barrier for when you're talking, sneezing, coughing, but a lot of those aerosols are going to easily filter around that face shield.

I guess it also does - I mean, the main reason that people wear them in addition to masks and aerosol generating procedures is because you can contract the virus through droplets that go into your eyes. So that's the main reason the face shields are recommended in addition to masks.

So, you know, I mean, I think for the patient population, surgical masks for most people will work. They're fairly lightweight and filter well. But, you know, I guess a face shield is better than nothing in those situations.

Christina Thompson: Cool. Thank you.

Coordinator: Our next question comes Julie Carey from NBC4.

Julie Carey: Can you hear me?

Dr. Danny Avula: Yes, Julie. You did it this time.

Julie Carey: All right. Third time is a charm. I did some telebriefing remediation in the last couple of weeks. Thank you very much.

You know, I've done so more stories this week about the problems with PrepMod. And, you know, so I got an update from your staff earlier this week.

But I'm just - I'm wondering, I mean, have you given up at this stage on trying to fix PrepMod? What's the progress on the homegrown system you're working on?

And thirdly, you know, I wonder, you know, wouldn't Fairfax County's system perhaps be one that you could adopt? I mean, it seems to be working for them without many issues.

So I'm just kind of wondering how it's looking at this end of the week for resolving some of those problems.

Dr. Danny Avula: Yes. I would not say we've quite given up on PrepMod, but we have rolled out VASE, the Virginia Appointment Scheduling Engine, in a parallel track. We are testing it this week and so far we've been using it to schedule the CDC appointments.

And it appears to be working really well. We have several health departments that are going to roll out VASE in their events next week. So I think it is very likely that we kind of do a phaseout of PrepMod and a phase-in of VASE.

So there's, like, one technicality to that, which is that PrepMod is still needed for the transfer of data to VIIS. Our team at VDH is building that out in VASE.

And so as soon as we have full confidence that that data is being transferred effectively then I think we can go with VASE as kind of a standalone solution.

A lot of health districts and other providers have shifted away from PrepMod and are actually switching back to VAMS. So VAMS, as you may remember,

was the original solution that the CDC offered all states to use. There were a lot of issues with it, which is why we moved on.

But it sounds like VAMS has actually been able to fix some of those issues. And while not perfect, there are districts that are able to get the job done with VAMS. They are able to do bulk uploads with that system. But it isn't sort of the end-to-end solution that ultimately we need.

Julie Carey: And a follow-up question on sort of an unrelated topic, I'm wondering is there any guidance or preference given to local health departments about how to deal with some of their clinic appointments?

And I'm asking specifically because, you know, Valley Health, unlike a lot of our Northern Virginia health departments, they offer up appointments most days at a particular time.

And then, you know, people take the step of going to grab those appointments as contrasted to what many others are doing, sending out appointments by email to very specific people. It means a lot of people from closer in Northern Virginia, Valley Health becomes the go-to.

But I'm wondering then whether that could jeopardize some of the people in those communities that really don't have the wherewithal, the savvy, to, you know, hover over their laptop. I mean, is there any sense about what's better or is it just, you know, all opportunities are good opportunities?

Dr. Danny Avula: Yes. I mean, earlier on when supply was more of an issue, we were really trying to discourage that, right? We really wanted - especially because we had started out doing primarily a per capita distribution, we didn't want that to be, you know, hawked by folks from other communities.

You know, now that we are at a pretty different stage, I would say that, like, we just - we're trying to feed as much vaccine out there as possible. And every community is going to use a multitude of strategies, right?

So Valley Health, I mean, if you look at the data in Winchester and surrounding Frederick County, the residents of those communities have really high rates.

You know, almost 20% of those communities have been vaccinated, no doubt due to Lower Fairfax Health District and Valley Health's partnership and just their ability to churn out vaccine at a high rate.

And then that also happens to be benefiting some of the larger attachment area that reaches into, you know, Loudoun and Lorton and some of those communities.

So, you know, at this stage, I wouldn't discourage any of that. What I do know the health departments are doing, not only are they sharing best practices with each other, but we are also outside of the mass vaccination effort.

We are layering in different strategies. And so getting out and doing community based events in a neighborhood or at a church or increasingly doing mobile vaccination events, you know, where many health districts have already either had as part of their assets a mobile vaccination van or have procured them over the course of the last few months with federal funding.

And then additionally our federal contractors will be bringing some mobile capabilities as well. And so as we think about the harder to reach populations, the homebound, as an example, we are working on parallel tracks to do mass

vaccination but then also to do the slower but just as important work with those high risk communities.

Julie Carey: Thanks very much.

Dr. Danny Avula: Yes, Julie.

Coordinator: Our next question comes from Amie Knowles from the Dogwood.

Amie Knowles: Hey, Dr. Avula. Thanks again for taking our questions. I heard that some religious groups have voiced that what they've referenced to as moral concerns over the Johnson & Johnson vaccine.

And I know you can't normally pick and choose which vaccine you get. But for religious reasons, can people have a say in which vaccine they'll receive?

Dr. Danny Avula: Well the way that we've designed vaccine rollout, Amie, is that people know what is being offered to them before they accept it.

So if you get an invitation to an event, you'll know that it's Moderna or Pfizer or Johnson & Johnson, and you'll be able to say yes, I'd like that or no, I wouldn't. And if you opt out of a vaccine event, you don't lose your place in line. You just hold your place until the next event is available.

So, you know, full transparency, everybody knows what vaccine is going to be offered to them and they can choose, you know, if that concern is a real one for them, then they can just wait for a Moderna or Pfizer event.



I think we will get to a point, you know, kind of May and beyond where different, you know, health systems or providers or pharmacies may carry multiple vaccines at the same time.

You know, I actually think, you know, April and May are going to be a big surge. We're going to get through a vast majority of the population.

But then into June, yes, we're going to continue having lots of vaccine but we'll be through most of our population and so the dynamics at that point will look very different. I think people will be able to go to a provider and choose a particular vaccine over another.

Amie Knowles: Awesome. Thank you. And then as a follow-up, you know, we've heard plenty about the side effects of the Pfizer and the Moderna vaccines. But I haven't heard as much about Johnson & Johnson.

So I was just wondering if you could go over what some of the side effects might be for J&J and how, if at all, they might differ from the other two.

Dr. Danny Avula: I would say that the spectrum of side effects don't differ very much at all. They're similar to Moderna and Pfizer. It is, you know, pain at the site of injection, sometimes some inflammation or redness.

And then in much rarer circumstances, it's some of the more allergic type reactions, some itching, some hives.

But what the Johnson & Johnson data showed is that the presence of side effects actually was less. People though with the J&J vaccine were getting fewer side effects percentage-wise than Moderna or Pfizer.

And, again, I think the anecdotal source so far, we've only been using J&J for a week now, but that seems to be consistent with what we're hearing around the state as well.

Amie Knowles: All right. Thank you so much.

Coordinator: Our next question comes from Luanne Rife from the Roanoke Times.

Dr. Danny Avula: Luanne, you might be on mute.

Luanne Rife: Oh, I'm sorry. I guess I forgot to go to the telecom lessons. Yes. So I was just wondering if you had any data or a feel for what percentage of the people who were eligible in Phase 1A since December to take the vaccine have done so and also now that you have, you know, the system to look at people who have preregistered that are in 1B, how does that match-up with what you had expected as far as interest in being vaccinated?

Dr. Danny Avula: So the easiest category for us to do that with is our 65 and up population. Just because of the way that the fields are entered into the VIIS database, age is an easy field to sort on.

So we can pretty readily pull the data by locality for the 65 and up population. I've done that with a couple of examples. Eastern Shore was at about 65%. Henrico was about 70 percent.

So, you know, I think many parts of the state are getting to 60 plus percent of their 65 and up population, which is part of why I can say with confidence, you know, the national data shows the 65 and up population across the country has 70 plus percent desired uptake and as high as 80% in some communities.

And it really kind of tracks with age. The older you are the more likely you are to get the vaccine. And that has been the experience so far from, you know, the long-term care work and then as we've branched out.

So I don't have a full analysis across the state of 1A and 1B. We have some ways to kind of estimate that and one of our team members is working on that right now.

So I think we'll certainly start to report that data as we finish those analyses. Because I think, yes, obviously it's helpful information to know, you know, X percent of your eligible 1B population did get vaccinated.

And we considered using that as a trigger to move onto 1C. But we also recognized that, you know, once you get past 60% the work it takes to get that final, you know, 10%, 15% is going to be significantly greater, right, the strategies, you use, the education you do, you work out in communities.

And so we don't want to not progress to 1C based on, you know, the additional work that's needed. We need to do both simultaneously. So we open up to 1C.

We continue to ensure people are vaccinated because obviously that contributes to herd immunity and has its own benefits. But then we simultaneously do the work to help people get off the fence in 1B.

But I would guess in the next week or so we'll have better data around the targets, you know, the percentage of 1A and 1B populations that we have vaccinated to date.

Luanne Rife: Yes. I was just wondering if, you know, those in 1A, especially health care workers who were hesitant, whether you've continued to see them change their minds and say, yes, I want it or if, you know, there's just a certain percentage that you're just going to have to go back and try and work with?

Dr. Danny Avula: Yes. I mean, we connect regularly with our health systems on this. And you may remember in the early rollout of 1A, sort of end of December, first week of January, the uptick initially was only about 50% to 60%.

What all of our health systems have reported is that their staff, after seeing their colleagues get vaccinated, after getting through their wait and see period, they have continued to see uptake.

And health systems are also asking for more vaccine for staff turnover. And so I think those are all good signs. What I don't have is, you know, of a given health system what total percentage of them have been vaccinated to this point.

But I would guess that health systems are actually collecting that. Well, yes, I know the health systems are tracking that internally so you may have some luck getting data health system by health system.

Luanne Rife: Thank you.

Coordinator: Our next question comes from Evan Watson from WVEC 13News Now.

Evan Watson: Hey, Dr. Avula. How are you doing?

Dr. Danny Avula: Hi, Evan.

Evan Watson: The last time we talked you mentioned that your staff was pulling numbers about long-term care facilities and their percentages of vaccinations, whether that would be residents and staff.

And I was curious if you had an update on that, whether you knew what percentage of residents and staff had been vaccinated so far.

Dr. Danny Avula: I know that is in my email inbox somewhere. I don't have it at the tip of my tongue. Can I follow-up with you this week and get that to you?

I think there is both. Yes, we do have some numbers around residents and staff. I just don't know it off the top of my head.

Evan Watson: Yes. I'll circle back and give you a call.

Dr. Danny Avula: Great. Thanks.

Coordinator: Our next question comes from Laura Perrot from WRIC.

Laura Perrot: Hi, Dr. Avula. Thanks again for taking our questions. I was just wondering if you could explain how these community vaccination centers that you were talking about are different from the current mass vaccination sites that we see through health districts like Richmond Raceway.

Dr. Danny Avula: Yes. The way they function, Laura, is not actually all that different at all. The big difference is that instead of being locally staffed and administered, they are state staffed and administered and they are funded by federal FEMA dollars.

So, you know, the processes that they're using, you know, pulling people and providing appointments off of the state pre-registration lists, really, almost everything about them and in some cases even the location is the same.

You know, I think that one of the ways we've thought about the CVCs is really providing that additional surge capacity in communities that need it.

So as we look forward to April and May and know that we're going to need to sustainably be at 70 plus thousand doses a day, CVCs will help be part of that solution.

I think the other reality is that health departments, you know, they've been at vaccination for a couple months but really the entirety of this COVID response for a year now.

And so what part of our decision-making with local health departments is recognizing that, like, their staff need breaks. Their staff are exhausted after a year of being in the midst of this high intensity response.

And to whatever degree we can provide that surge capacity and a break over the next couple of months as we continue to filter vaccine through pharmacies and providers. Because, you know, after June we're going to need to think longer term about what happens with the vaccination.

Certainly kids in the fall or older kids at least will be part of that equation. Boosters may be part of that equation, younger kids starting into next year.

And we're not going to be in this federally funded emergency crisis mode throughout all of that. And so we really need to start thinking longer term about what are the sustainable pathways?

How do we make sure that we've got the infrastructure to support pharmacies and other providers, where people normally go to get their vaccines? So the CVCs fill very much a short-term surge solution, give health departments a respite and then we will transition in the fall to more sustainable pathways.

Laura Perrot: Thank you. And then one quick follow-up. I think you mentioned earlier that about 19-1/2% of the Virginia population has been vaccinated. Is that fully vaccinated or does that include people who have gotten their first dose?

Dr. Danny Avula: Sorry, no. That's at least one dose. But that number does include some people who are fully vaccinated because it's first doses of Moderna, Pfizer plus J&J.

Laura Perrot: Got you. Thank you.

Coordinator: Our next question comes from Shayne Dwyer with WSLS.

Shayne Dwyer: Hi, Dr. Avula. This part of a follow-up almost to the question from NBC4 in DC.

Down here in Roanoke we've uncovered these groups on Facebook that are basically being used by almost 10,000 people in these groups to game the system for appointment registration for the partners, so for Kroger, Walgreens, CVS and the like.

And basically we have people who are - now we've got dozens of people openly admitting that they drove from Alexandria or from Richmond all the way down here to Roanoke to get an appointment at one of our locations.

And they're talking about how they use these strategies, about how they stay up and they're right there so they can click and refresh the page as soon as the appointments become available and then they tell everyone else.

And so it's like a batch of appointments will get launched or released at one of our local stores and it could be gone in just a few minutes and all sourced up by people who are not in the Roanoke Districts nor are they really anywhere close to the Roanoke/Allegheny District.

So obviously there's nothing you guys can do to stop it. But from an ethical standpoint, this obviously is hurting folks in our District who I've heard from personally who say they still cannot get appointments for their eligible family members for the vaccine.

Dr. Danny Avula: I've heard a little bit about that, Shayne. I think the description you just provided is much more detailed than I had previously been aware of.

I don't love it. I mean, I do understand the desperation that so many people are facing to try to get vaccine. And so, you know, we need to acknowledge that reality.

But I think our consistent message along the way has been, you know, we should at every turn allow the folks who are at higher risk to get to the front of the line.

And I think that is most true for our 65 and up population, for people with severe underlying conditions, you know, those who are under active treatment for cancer or bone marrow transplant patients. You know, there are certain dials for patients. There are certain categories we know put you at higher risk.



I will say that, you know, where we are kind of now and heading into the next couple of weeks, that's slightly less of a concern because really, you know, everybody who is eligible in 1B based on a risk category will be able to get vaccinated in the next, you know, three-ish, four-ish weeks here.

And so I don't know. I think that, you know, in the way that we've rolled out our vaccination effort, we want to balance priority and not create too many administrative burdens, right?

So for example, people have suggested, you know, some kind of attestation or a proof of an underlying medical condition. And what that does at the point of vaccination is it really cuts down your throughput time and it potentially makes people who don't have ready access to a doctor or a primary care provider, it creates an undue hardship for them to get vaccinated.

And so, you know, there's no way to perfectly deal with all of that. And I'm hoping that people will, you know, both be honest about their inclusion criteria but also think about members of their community who actually are at higher risk and need the vaccine more and therefore choose to just wait their turn.

Shayne Dwyer: And as a follow-up to that, I mean, it's not even beyond the point of someone, you know, choosing to feel that they are more important than another person or not think about their neighbor and the consideration.

But it's almost the gamification of it and the arbitrage that is just, like, you know, here's a link. Get it. Let's, you know, all work together. In the groups they describe themselves as crowdsourcing to get appointments.

And this has kind of evolved. I don't think this was the original intention. But they would just post and say, hey, you know, Roanoke just launched all of these appointments. Go get them now.

And so, you know, these are coordinated efforts, you know, on these Facebook groups to kind of just game the system and get all the appointments when in our District, particularly in this neck of the woods in Southwest Virginia, you know, we have people who don't even have Internet that can't even get to these Web sites.

So they're still trying their hardest to do it and they are not getting access to these appointments. And, you know, I don't know that it's exactly because people are coming in and scooping them all up. But when you lay it all out, it's pretty tough to ignore.

Dr. Danny Avula: Yes. No, I hear you on that. I mean, I will say in Southwest Virginia because the approach these health departments have been taking and, you know, just really the clear effectiveness of the health departments and health systems and their network of partners, they have had really high rates of vaccinations.

So I guess despite some of those folks who are willing to travel, they're still getting a heck of a lot of people who live, you know, in Roanoke and then out through the Cumberland, Lenowisco and Mount Rogers Districts.

So, yes, like I said, we can't overly restrict and we need to some degree trust the honesty and goodwill of people. But we are at a stage where we're going to get through everybody with the course of weeks now.

And so I'm just not sure it's worth spending too much time trying to divert from those scenarios.

Shayne Dwyer: Thank you. I appreciate it.

Coordinator: Our next question comes from Sarah Rankin from Associated Press.

Dr. Danny Avula: Sarah, are you on mute?

Sarah Rankin: Yes. I'm sorry, Dr. Avula.

Dr. Danny Avula: Hi.

Sarah Rankin: What is your follow-up about President Biden's first vaccination goal? Does it alter the state's plans in any potential way or was it the case we were sort of on that type of path?

Dr. Danny Avula: Yes. No, it hasn't changed anything for us. I mean, I think we made our projections based on the supply numbers we were hearing. So nothing has changed. Like we all throughout this have been totally committed to getting vaccine out as quickly as possible.

I would say the only thing that - not that specific announcement but the one the previous week about retail pharmacy opening up to teachers, again, it didn't have a huge impact in Virginia because we already, in so many districts, we already had about 70% to 80% of our teachers had at least had the opportunity to be vaccinated.

When we looked at the data last week, I think 67% of teachers had had their first dose. But it has resulted in more accessibility to teachers through the retail pharmacy program. But the actual date of May 1 hasn't changed anything for us.

Sarah Rankin: Okay. Thank you.

Melissa Gordon: Hello, everyone. 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 Max Marcilla, NBC29.

Max Marcilla: Hey, Dr. Avula. A quick question for you. And I know you talked about the supply, the numbers of supply going up that will be helpful when you eventually go into 1C and beyond.

But I'm wondering what plans the state has in place to prepare for post-1C when virtually everyone, 16 or 18 and up, will be eligible. So how beyond the, you know, sheer numbers of supply do you plan to handle the rise that will come when basically anyone is eligible?

Dr. Danny Avula: Yes. Thanks, Max. So as we look through the month of April and we work our way to about, you know, 700,000 doses a week, it means that we do need to build the capacity in the short-term to get to about 100,000 doses a day.

And, you know, what do our numbers actually look like? I think at the beginning of April it will be about 600,000 doses a week. And then towards the end of April into May we could be seeing numbers of about 700,000 a week. And so that's what we're building our channels around, right?

We are, you know, kind of mapping out what is the max capacity of our health department infrastructure? What is our mask capacity of our hospital infrastructure?

We know that, you know, through the FEMA dollars that are supporting our community vaccination sites, they can get up to 270,000 doses a day at their peak. And so that really is how we get to that number.

Yes, I think our original four channels will be able to meet the bulk of that. But the CVCs really need to get us over the hump and to get the speed of vaccination that we want to get everyone at least their first dose by the end of May if not before.

So, yes, that's the primary strategy is adding the CVCs for surge. And then as I said earlier, you know, thinking longer term about what the sustainable plan is and that's really working through our pharmacies and providers, which is where people normally go to get their vaccine.

Max Marcilla: Thank you. And just one quick follow-up. I'll be respectful of time. The May 1 deadline that President Biden set, I know you said earlier you feel confident you'll meet it.

Could you just describe how you see the state's deadline and how you think you'll be able to meet the May 1 deadline to have everyone eligible?

Dr. Danny Avula: Yes. I mean, so what that functionally means for Virginia would be a decision to go into Phase 2 by May 1 because Phase 2 is the general population.

We really, I mean, even prior to the President's announcement, I think what I probably told you all last week on this call was that we were looking at the second or third week of April to be able to get through all of our 1B population and that everybody would be moving from 1B to 1C and then into 2 on, you know, kind of their own pace.

It looks like based on uptake and the addition of these CVCs, that one 1B timeline could be even faster, right? For some parts of the state they're going to be looking next week or the week after at moving from 1B into 1C. And then they're going to get through their 1C population in about a week.

The 1C category is not very big at all. And we're already starting to plan closed pods with some of the 1C employer groups for that first week of April.

So I think, you know, those are some of the strategies that we're going to use that we're kind of thinking ahead. We know when we're going to get the 1C units of vaccine. We've set up - there's opportunities for the 1C employer groups. The CVCs are going to help with a lot of that surge capacity.

And then increasingly, you know, hospitals were a big part of our strategy early on when health care workers in 1A were prioritized. And then vaccine distribution shifted out to health departments and other community sites to get to the masses.

And now hospitals are ready again to take on some of those doses and both treat their 1B patient populations but then also in many cases be community-based to help with that capacity as well.

Max Marcilla: Thank you.

Melissa Gordon: And 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 will be able to access these documents at [vdh.virginia.gov/coronavirus/media-room](https://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: That concludes today's conference. Thank you for participating. You may disconnect at this time.

END