

**Virginia Department of Health Tele-Press Conference on
Virginia's COVID-19 Vaccine Developments
Moderator: Melissa Gordon
April 30, 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: 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: Good afternoon, everybody. So today, six point almost two million doses administered, a little over 44% of the population that has at least one dose. And it was a significant week in the vaccination rollout. You know, we've

been talking for weeks about how different parts of the State have been meeting demand at different points, but really this past weekend was the first time that every part of the State, we really saw demand peak.

And now that means that we are pivoting all over Virginia in a different direction, right, to make sure that people understand their options, that we make vaccination as convenient as possible, and that we really start to design our vaccination efforts to be more targeted, more tailored, more neighborhood focused, more vaccine coming through primary care providers, and really allowing people opportunities, not only for the convenience of vaccination, but also for the opportunity to talk through questions and hear from somebody that they trust.

And so, what I see happening - you know, it's already began to ramp up over the last few weeks, but what will really all collectively lean into in these coming weeks, one, is pushing more and more vaccine to primary care providers.

You know, survey after survey shows that it's your primary care provider that you trust to make health decisions around. And we want to give as many people as possible, the opportunity to have those discussions with their primary care providers, and then be able to get vaccinated, if they choose to make that decision.

And so, allowing providers more access and making it more convenient to actually manage the vaccine, is a big part of that. The federal government is helping some with that. Pfizer, as probably the most significant example, typically comes in trays of 1,170 doses. Starting in May, they are going to significantly reduce that.

I think in some cases, it's going to be 460 doses. In some cases it will actually be 150-dose packages. And so, that will make it more and more possible for smaller group practices to be able to receive vaccine. We're also going to - have already started to change our messaging with providers, letting them know we are now in a different phase of this rollout, and where up until a couple of weeks ago, our messaging has always been, use the - whatever vaccine you get, you're expected to use the week that you get it, because vaccine had been in such short supply.

But now that we're on the other side of the supply demand curve, we - and providers should know that it's okay for them to have vaccine, and to be able to carry it over into the next week, and just to use it per the manufacturer's guidance.

So, that's a big shift you know, and I think means more providers will be willing to take small amounts of vaccine, and have it available for their patients. And then in addition to that, more mobile vaccination, more community pop-up vaccination, I think we'll just continue to see a lot of different innovative examples of organizations we're partnering with, and locations that we're setting up vaccinations with.

As I've talked to my colleagues around the country, we're all kind of sharing best practices with each other about, you know, setting up vaccination in the farmer's market or at upcoming elections. So, I think these are the kinds of things that you'll see more and more of, because convenience is such an important piece of the equation right now.

You know, I think there's a large segment of the population that hasn't gotten vaccinated, not necessarily because they don't want to, but because maybe

they have had trouble navigating the Web site or just, you know, it wasn't a high enough priority for them to make an appointment and show up somewhere where they had to wait in line.

But - so we really need to understand that convenience is a major factor for this segment of the population. We'll continue to make vaccine available, and really work hard to get the most vulnerable vaccinated. So, that includes our elderly, those with underlying conditions.

I don't - yes, it's most important that we try to keep working on those populations, but as we try to get as many folks vaccinated as possible, we know that now we're looking at kind of this 16 to mid-30s segment that we're going to have to lower those barriers for.

Other changes that we've made, the vaccinate.virginia.gov site continues to get easier and easier to navigate. The call center is still incredibly helpful and more streamlined. We're no longer - in almost every district, no longer doing pre-registration, because in every part of the State, if you want an appointment, you can make that, in some cases the same day, in some cases the next day.

We've also shifted a lot to walk-up vaccination. So, especially our larger sites, the community vaccination centers, are able to accommodate walk-ups. And then, because we've gotten a lot of feedback around the federal system, the vaccine finder system being a little bit tough to navigate, there being a lot of different pharmacies in some communities, what we've done on the vaccinate.virginia.gov site is, created a pathway for you to put your address in, and that will immediately take you to either a health department or a CVC site where it will be much easier to get an appointment either same day or the following day.

Other things that have been going on, obviously Johnson & Johnson was reinstated this past Friday. We messaged that out to providers immediately, and probably mid-week this week, providers have started to put Johnson & Johnson back into use.

Haven't heard much feedback so far about what that uptake has been like, or whether there's been resistance by patients about the Johnson & Johnson. So, probably next week, we'll have a better sense of what that uptake has been like.

And then the other kind of news on the horizon is that the CDC continues to affirm the likelihood that we will have an approved vaccine for those 12 and up, sometime mid to late May. And that'll start with the Pfizer, and they anticipate the Moderna will be maybe two to three weeks behind that. But that means that - you know, that's a large segment of our population who will be newly eligible in a month or less.

So, a few different pathways for that adolescent group. We are continuing to recruit pediatricians to be approved vaccination sites through the CDC process. They can obviously go through [vaccinate.Virginia.gov](https://vaccinate.virginia.gov) and find appointments for Pfizer clinics initially, because I said we anticipate to be approved for the 12 and up, either through the larger reclamation sites, through health departments, or through pharmacies.

And then we are engaging schools. Most of our local health departments have already reached out to their school systems, and we are meeting with all the superintendents in the coming week, to just talk them through the options so that once we do get the announcement and we get approval, we hopefully

have probably what, a three-week window before schools go out for the summer.

So there may be a real opportunity to do onsite school-based vaccination for that population. Okay. What questions does that raise for everyone?

Melissa Gordon: Thank you, Dr. Avula, for that update. 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.

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 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. Our first question comes from Amie Knowles from The Dogwood.

Amie Knowles: Hey, Dr. Avula, thanks for doing this today. I think we've all missed you. First of all, I was wondering, you know, now that we're a few weeks out, in your opinion, what was the biggest impact that the Johnson & Johnson pause had on Virginia?

Dr. Danny Avula: Oh, Amie, it's so hard to figure it out because of the timing, right? Like the same time that that Johnson & Johnson pause was initiated, really, I mean, like coincided pretty well with where demand was already starting to drop off.

And so, it's really hard to know whether what we're seeing is a result of the J&J pause and the potential for overall hesitancy that that may have led to, or whether it just was coincidental.

I think in terms of our rollout, the biggest impact was in our colleges and universities, right? We had a number of vaccine clinics set up for those institutes of higher education that week and the following week. So, many of them switched over to two-dose vaccines.

Some of them held out for Johnson & Johnson and will be offering those clinics next week. But I did hear some anecdotal response that, you know, they didn't get as many college students as they were expecting to get vaccinated. And then some, you know, hypothesization that - was that because it was a two-dose versus J&J.

So, it's really hard to tell. I think that what we're seeing outside of IAT settings is that that younger population is not as motivated to get vaccinated anyway. And so, I do think back to my earlier comments about the convenience factor and really, you know, doing more school-based vaccination, you know, for parents, like having it coincide with the pediatrician's visit, I think we're just going to have to find more and more ways to make it ultra convenient for that segment, because otherwise, like the value proposition for young, healthy adults, is challenging, right?

I mean, they say, it's not a big deal. If I get it, I'll be fine. And by and large, they're right. But we - this whole idea of herd immunity, that we need to get as many people vaccinated as possible so that we don't risk another surge of disease. Like that would be the worst thing for all of us, is if we remain - if we have enough people remaining that can actually be infected. And that's why we need to keep vaccinating as many people as possible.

Amie Knowles: Awesome. And then as a follow-up, I've heard that there has been a lot of variants spread, especially in Southwest Virginia. I was just wondering if you could touch on why that might be.

Dr. Danny Avula: Well, so the thing we know about variants is that they are more transmissible, at least the small handful that we've identified. The UK variant, the B.1.1.7, the South African variant, the B.1.351, those do appear to be somewhere between 50 and 60% more transmissible.

We also know, especially as we look in other States, that it's a younger population that's driving it. It's youth sports. It's high school kids. It's college students, and sort of their more risky behavior, paired with the introduction of a more virulent disease, a more - like an easier - a more contagious disease, is leading to higher rates of transmission.

I think that is concerning, certainly in pockets of the community where we don't have really high vaccination rates. What we have seen in other parts of the country, is that while case rates are surging in that younger adult population, it is also leading to an increase in hospitalization rates for 30 and 40 year olds.

And we haven't yet seen that translate into higher death rates. So, I hope that that's not the case because most younger people, even if they have severe illness and are hospitalized, are going to rebound pretty well. But it is concerning that there are enough people that are having severe disease.

And we know that underlying conditions like obesity and diabetes and hypertension, certainly put you at higher risk for negative outcomes, and that's what we're seeing. And that hasn't happened in Virginia yet, but obviously we

want to prevent that if possible, and the best way to do that is to get more people vaccinated.

Amie Knowles: Thank you.

Coordinator: Our next question comes from Sabrina Moreno from the Richmond Times Dispatch.

Sabrina Moreno: Hi, thank you so much. So, apologies if this sounds a little bit morbid, but almost a month after being vaccinated, kind of how are you moving through the world differently, and what still keeps you up at night?

Dr. Danny Avula: Well, I would say, Sabrina, that the intensity of the work has felt very different the last couple of weeks, right? I mean, I think going from three plus months of there just not being enough vaccine, everybody like clamoring for it, just the sense of urgency and desperation that so many Virginians had to get vaccinated, that has changed.

And, you know, moving to the other side of the supply demand curve has really led to just a change in strategy. The work is just as important and a lot harder, right, as we progress towards that 75% goal, we - it's going to be slower. It's going to be a lot more challenging.

And so, it's a very different pace of the work. I think for me personally, having been vaccinated, I continue to be encouraged by the way that guidance is changing, right? I think the CDC has taken a very evidence-based approach to their guidelines. They just, you know, in the last couple of days, released new guidance for mask wearing outdoors for people who are fully vaccinated. And we've translated that into guidance here in Virginia.

And so, that feels better, right, just to know that when you walk outside and you see more people not wearing masks, but doing it safely, because we know that that risk of transmission is incredibly low, that feels like progress. That feels like okay, like this summer, things are looking up and things will get better.

Obviously, there's still the sense of urgency around the core of this work. And so, my life is definitely feeling a little bit easier, but we'll still be at it. The team will still be at it for the remainder of the year, no doubt.

Sabrina Moreno: And I know much of our behaviors are based on a personal risk analysis, but from a public - kind of from a public health standpoint, you know, for people who have - what will safety - what will feeling safe, kind of look like? And for people who have battled racial disparities over the past year and are still the population seeing lower vaccination rates, you know, what might that look like for them?

Dr. Danny Avula: Well, I mean, I hope that the most compelling thing is the data around people who are fully vaccinated. So the CDC updates the national data basically every week. And right this week, as of, I think, two days ago, something like that, 95 million people across the country who are fully vaccinated, so, you know, two weeks after their final dose.

And of that 95 million people, there have only been 9,200 breakthrough infections. And so, you know, remember, we were reporting during clinical trials, efficacy rates are like 90% against getting COVID. You know, these real life numbers are more like 0.005 or 0.007%.

And it's - I mean, it's really astounding how effective vaccination has been.

And so, I hope that as people are thinking about that risk benefit calculation, and thinking about, you know, what do I do - need to do feel safe again, that that data will compel people to say, okay, I just need to get vaccinated, because at this point we've had, you know, over 150 million doses out there, probably 200 million at this point. And the safety and effectiveness are just like nothing we've ever seen.

So, that's the first answer, is that hopefully it will compel more and more people to get vaccinated. I think the other piece of it, especially as I think about schools, is that we need to think about things in terms of their relative risk, right?

This last year, schools - like a lot of schools, particularly ones that remained closed, did so because teachers and families didn't feel comfortable. They were too concerned about the risk of the spread of COVID. And despite the data, right, like there's so much data to show that schools that were able to adopt mitigation efforts, really showed incredibly low rates of transmission.

And now at this point, where the bulk of our population either has been vaccinated or has had the opportunity to be vaccinated, that we look, what's on the other side of that risk calculation? We know that kids not having access to school, has had really significant impact on their lives.

It's impacted their behavioral and emotional health, and it's impacted their social development, and it's certainly impacted their academic development. And so, I think we've just got to keep looking at, what are the relative risks? What are we giving up, because we are afraid of what - understandably, of what we've all lived through this last year.

And I think part of that is on us, right? Public health - like part of our job is to

frame these risks in ways that people will understand, and then to use a combination of the data and like effective messaging to help shape policy and to help shape behavior.

And so, I do think there are ways that we've got to do better jobs with helping the public understand, you know, given where we are with vaccination, what are the risks now and what are we giving up to not start to take steps back towards normalcy?

Sabrina Moreno: Thank you.

Coordinator: Our next question comes from Evan Watson from The WVEC.

Evan Watson: Hey, Dr. Avula, thanks for this today. I wanted to ask just kind of a number from the projection standpoint. I know you've mentioned 75% for many months now, mentioning that we're at the peak now. Is that still a realistic projection? And based on where we are, how would you say to people who might ask, how safe are we at this point in terms of how many people have been vaccinated?

Dr. Danny Avula: Yes. You know, 75%, Evan, has always been like our best guess at what it will take to stop the transmission of the virus. Now, it's not - we don't know that for sure, right? We don't know that once we hit 75%, everything's going to be fine. That number could be 70. It could be 65.

That number really came from thinking about what we know about COVID transmission, just how contagious it is, comparing that to our experience with other viruses that have similar transmissibility, and ball-parking that, you know, it's going to take about 70 to 80% of the population to really stop transmission in the community.

So, that 75%, I guess, I frame all of that to say, it's not - that's not a hard and fast number. It's not like we stop vaccination after we get to 75%. And it's not like we have failed if we don't get to 75%, because there are other factors at play, right?

So if we are at 60%, but we see transmission pretty much disappearing, then that's reassuring. And what we'll see at every step of this, I think Virginia has been very thoughtful and very data-driven in this process, but it's led to kind of these incremental steps, right?

We're not just opening up at all times. We're monitoring disease rates. We're taking one step at a time and seeing how that impacts the transmission of disease. So, hopefully that's helpful in terms of like how we think and talk about herd immunity, because I don't want people to say, okay, like we can't do anything until we get to 75%, because that's just not the case.

So, to the question of, how successful can we be, right now, you know, we're 44% of the entire population of Virginians, but if we look at what that number is out of eligible Virginia, so right now only people 16 and up can get vaccinated, that number is about 57%, right?

So, we're actually making really good progress in that 16 and up population. And it's not like it's completely dropping off. I mean, we added 92,000 doses over the last 24 hours. And so, there are still - there's still lots of vaccination happening, and I absolutely think that we can get pretty close to that target goal is 75% right now of the eligible population, and then when that opens up to the 12 and over, then you know we're going to have those - that same ballpark goal for each successive group of eligible individuals.

Evan Watson: Great. Thank you. And for that second part, kind of how safe are we now? Is it fair to say that, you know, we're seeing the increases when it comes to the improvements, when it comes to cases and everything else, but the more people vaccinated, of course, the better that gets, and right now we're not to the satisfied points for getting there. How would you kind of quantify it, I guess?

Dr. Danny Avula: Yes. I mean, we still have circulating disease. Obviously, the last week has been really encouraging. We've had about a 30% decrease in case rates in Virginia over the last week, and that is reassuring. And I think, you know, the new CDC guidance is reassuring. And all of that, I think it's a recognition of the progress that we've made to date.

I do think we don't want to take that too far, right? Like we throw caution to the wind, we stop wearing masks, and we just say, okay, everything's fine. Let's just go back to life the way it was. We absolutely risk a new surge, and we absolutely risk the spread of variants like we've seen in other States.

And so, I guess, if I were to succinctly answer the question, we're not out of the woods yet, and we want to continue to be careful in the context where we need to be careful, and we want to be able to ease up or rest more comfortably in situations where the risk isn't as high.

So, you know, fully vaccinated, small groups outside, the risk is not really that high. Not vaccinated, lots of people indoors, much higher risk. So, I think it is - yes, I mean, we clearly still have scenarios where we've got to take caution.

Evan Watson: Thanks

Coordinator: Our next question comes from Elisha Sauers from the Virginian-Pilot.

Elisha Sauers: Hi, Dr. Avula. I was wondering, do you have data on the registration list? Are we tapped out on people on the registration list, or what percentage is left on there?

Dr. Danny Avula: We have invited almost everybody who has pre-registered at any point. Now, because different communities have continued to use pre-registration, there may be a handful where there - where we still have names on them. But this last segment, since we all went into Phase 2 collectively on April 18th, there are probably still a few thousand names that we need to be inviting to appointments.

I would guess that of that group - so I don't have an exact number for you. I can follow up on that later today if it's helpful. But I imagine that a large number of those people who ended up pre-registering, also probably just found an appointment, because almost everywhere in the State, you can go and get a same day or next day appointment.

So, I suspect that the names that are on the list, probably will not yield that many appointments, because I imagine many of those people would have gotten vaccinated somewhere else.

Elisha Sauers: And do you have data on uptake for second doses or failure to return for the second dose?

Dr. Danny Avula: I do. I pulled those earlier this week. The numbers are about 160,000 individuals in Virginia who have not - who've received their first dose, but it's been longer than 42 days since their first dose, and they have not received their second dose.

So that's about 9.4%, I think, of the population that got a first dose, didn't get a second dose. We are kind of digging into, what are the reasons for that? I think some of that is the reality that, you know, people who may have not been that enthusiastic about getting vaccinated in the first place, they did. Maybe they had some symptoms.

It was going to be that much harder for - to convince them to come back and get a second dose, especially when a lot of the recording was saying that second dose, and some of - you know, a lot of people's personal experience, is that the second dose actually has worse side effects.

So, I think that's probably a large chunk of people. I think some of that was also just systems that we needed to shore up. At the beginning of this vaccine rollout, a lot of providers were hesitant to make appointments when they didn't have vaccine in hand, yet we were saying, hey, go ahead and, you know, make appointments, schedule that second dose appointment at the time that you give the first dose. That was not happening universally across all providers.

And so, I do think that some of the like challenge of that system, some of the challenges of making that second dose appointment, probably contributed to some of that. What we're doing right now is, all of those, you know, 160,000 people, were having our statewide call center do outbound calling to them, and seeing if we can get them to come to an appointment immediately.

I think the reassurance I would provide is, you know, the manufacturer recommendation for Pfizer is three weeks. For Moderna is four weeks. The CDC offers a grace period of up to six weeks, but there has been, you know, ongoing - there have been ongoing studies that have shown that booster shots,

that second dose, even beyond the 42-day period, is still very effective, and in some cases, more effective.

And so, you know, we haven't - those studies are kind of all over the place, but all that to say, I don't think that there's going to be a significant drop-off in the effectiveness of the second dose based on what we've seen so far.

Elisha Sauers: Okay. Thank you.

Coordinator: Our next question comes from Taylor Coleman from ABC13 News.

Taylor Coleman: Hi, Dr. Avula. My question is, is it safe for a person to receive the Moderna vaccine for the first dose, and then the Pfizer for their second? And what's being done to make sure that that doesn't happen?

Dr. Danny Avula: Well, it's certainly not recommended. I mean, we want people to ensure they get the same dose of - you know, that there's consistency between the first and second dose. There have been some, or there are ongoing studies about the efficacy of crossover, because it does happen from time to time, and enough so that they're actually conducting clinical trials on this.

What we do really ask people to do, is bring their vaccine card so that the provider can actually double check and say, was it Moderna the first time? And if so, let's make sure we give the Moderna. And the other thing that is happening pretty consistently now, like I was just talking about the fact, you know, with our first and second dose drop-off, earlier on in our campaign, there wasn't a ton of consistency about making that second dose appointment.

That has happened much more consistently in recent weeks. And so, that's the

other thing we're doing to try to minimize the opportunity for people to, you know, not get the right dose for their second dose.

Taylor Coleman: A follow up to that. Is it - are you seeing cases where this is happening, where someone is getting a mix of the two doses? And if so, do you have a number to support that?

Dr. Danny Avula: We definitely have gotten reports, right? We periodically get emails. I would say - I don't know. I would have to look at what that exact - now, I feel like I'm seeing messages like that once every couple of weeks. So, I don't think it's happening a ton, but we'll have to pull the data. Taylor, if you wouldn't mind shooting that question to Melissa Gordon, I can get - I should be able to get back to you by today or tomorrow.

Taylor Coleman: I appreciate it. Thank you.

Coordinator: Our next question ...

Dr. Danny Avula: Yes. And one more follow-up on that, Taylor, right? The CDC guidance around that is that you don't get another dose, right? So, if you start with Moderna, and then there's a mix-up and you get Pfizer your second dose, it is not recommended that you go back and get a Moderna dose at this point. And so, I think this is where we're waiting for some of the results of these crossover trials.

Taylor Coleman: Got it. Thank you.

Coordinator: Our next question comes from AJ Nwoko from NBC12.

AJ Nwoko: Hey, Dr. Avula, real quick, I missed the first part of the call. So, for my first question, could you just quickly run through the updated data again from that first part one more time for me?

Dr. Danny Avula: Yes, sure can. The total doses administered as of today, AJ, 6.19 million total doses. 44.3% of the population has at least one dose. And that's - as I explained this a little bit earlier, that's 44% of all of the 8.5 million Virginians. When you take into account that only 16 and above are eligible, that - the number of people with one dose jumps up to about 57% of eligible Virginians that have received at least one doses. And then 30.6% of the population that is fully vaccinated either with J&J or two doses of one of the other vaccines.

AJ Nwoko: All right. And then real quick, I know you mentioned schools, or you're working with schools and are in talks with some superintendents about possibly vaccinating kids potentially before the end of this school year. Would those vaccines be modified versions of the Moderna and Pfizer or something different entirely?

Dr. Danny Avula: No. Same doses, that's what's being tested in these clinical trials. And I - so what - just again to repeat on that, what we're anticipating is that 12 and ups will be approved by the middle or mid to late May. So, I do think that the dose numbers are changed or slightly smaller doses for the ongoing clinical trials for those kids who are ages two to 11.

I need to confirm that, but we'll obviously have more guidance on that before we have any approval on those vaccines. And that, we're not really anticipating until the beginning of 2022 for that two to 11 age group. But from a process standpoint, what will happen is that, you know, Pfizer has already submitted an expansion of its EUA to the FDA.

And so, what that means is, the FDA is looking at all of their data from their 12 and up trials, and then they will make a decision. You know, pretty soon after the FDA makes that decision, if it's to approve, then the Advisory Committee On Immunization Practice, ACIP, they then review that data and make specific recommendations on dose size and what the interval is and all of that. But at least for the 12 and up, we don't anticipate any changes there.

AJ Nwoko: Awesome. Thanks.

Coordinator: Our next question comes from Gene Marrano from WFIR News Radio.

Gene Marrano: Hi, Dr. Avula. A question about the 12 to 16 year olds and maybe the two to 11 down the road. Is that going to be a tough sell job, do you think? Or, I mean, are you going to go through the schools to try to promote it? And I'm just wondering if you think that might even be able to bring some of their vaccine-hesitant parents into the fold. If the kids want the vaccine, maybe the parents will come along.

Dr. Danny Avula: Yes. Jean, it's a great thought, and we've actually thought about that a lot about, how might this be, you know, a care for parents or at least, you know, again, the convenience factor for parents who are on the fence? I do think, you know, like culturally, we're a lot more open to (unintelligible) vaccinations.

And, you know, I don't - especially while the vaccine is under an emergency use authorization, I don't think there's any scenario where this is a required vaccine for schools, but I do think the more convenient we make it for kids to get vaccinated in schools, where there is the sort of the peer momentum of lots of people getting vaccinated.

And then, you know, I've even talked to my own kids who are teenagers and other friends' teenagers who feel like they are choosing to get vaccinated. Like they want to be vaccinated. They see what's happened to our society, and want to be part of the solution.

So, I do think that there is a large number of 12 and up who are going to make their own decisions, who really want to get vaccinated. Ultimately, they need parental consent, and an adult to be with them when they get vaccinated. So, yes, I do think it will present some opportunities to get some of those vaccine-hesitant parents, but I look forward to that.

Gene Marrano: Thanks, doc.

Coordinator: Our next question comes from James Jarvis from InsideNoVA.

James Jarvis: Hi, Dr. Avula. So, there's - I want to address some of the comments you made earlier in the call about convenience, making the vaccine more convenient for communities that have trouble accessing it, or are maybe hesitant about getting it. And there's been a lot of controversy about whether or not mass vaccination centers are the best way to do that.

And I know that you addressed - sort of addressed that by, you know, mentioning, making it more convenient in locations like churches and mobile clinics and community centers and things like that. But I'm curious if you have any like qualitative or quantitative data that helps - would help understand whether or not you think that these racial and ethnic disparities between people being able to get the vaccine, is because of hesitancy or is it because of accessibility?

Dr. Danny Avula: Yes. You know, I think it might be a combination of those things, but I should also say that we've done a pretty good job in Virginia when - you know, not as good in the African-American population. Our State is 19% Black.

Our numbers are about what - I think I looked two days ago, it's 14.1% of those who were vaccinated, are African-American. But we've actually done really well in our Latino community. So we're about nine, 9.5% Hispanic, and we're about 10.5% of our vaccinated population that's Latino.

So, we've done a lot of work over the last four months, and even prior to us having vaccine, to cultivate relationships, to think about what networks and what communities we needed to be engaged in. We really have racial equity be front and center in all of our planning.

You know, our Health Equity Work Group, led by Dr. Janice Underwood, has been, you know, part and parcel of all of our vaccination efforts. And it has - it's taken different approaches, right, because - and for lots of different - let me give you one example with our undocumented population.

So, we know that that concept of mass vaccination that requires you to go in to the State Web site and to enter a bunch of information onto a State database, like we know that was a barrier for a lot of people. And so, we - even early on, when we first rolled out mass vaccination sites, we tried different approaches.

We had about 200 slots a day in Prince William County, for example, that were held for people who didn't have to register. They - we would work through different communities. We would work through different community leaders, and we would say, hey, just bring your group of 200. This is your

day. They don't have to go through the registration process. They can just give the minimal information so that we can follow up for a second dose at the time of registration.

We've also seen in recent weeks, as we've shifted over to walk-up, as opposed to making appointments and registering on the Web site, we have seen surges in some communities. Just last week in Roanoke, they shifted to a walk-up and had about 550 people in an afternoon that came and did walk-up registration.

So, I think we are seeing these different tactics yield success in communities that weren't going to come to mass vaccination sites that they had to pre-register for. And again, I think the more that we can do this in partnership and in connection with trusted people on the ground, right, with the NAACP, with your mosque, the more likely it is that people who may not trust government, but do trust their faith leader or do trust their, you know, tenant council leader, would actually show up and get vaccinated.

So, you know, I don't have quantitative data, but I do think there's lots of stories, lots of headlines. It's been a big part of our work over the last four months. And as we shift away from the urgency around like large scale delivery, it will be - more and more of the work will be these small, but high partnership on the ground efforts.

James Jarvis: And just as a follow-up. If it gets to a point where, you know, even if, you know, you've made considerable efforts to combat misinformation and to make vaccines readily accessible, you know, and available any time of day and to whoever wants one, and if people - if there is a segment of the population, you know, in the State that doesn't get the vaccine because they

don't want to, from a public health perspective, how do you - what are the next steps?

Dr. Danny Avula: Yes. I mean, this is where we've started to shift some of the efforts in segments of the population and in communities where we just have more outright vaccine resistance, because in some cases, like what we're talking about Black and Latino populations, let's say as an example, and obviously there's a lot of variability even among those groups, but what we initially looked at as vaccine hesitancy because of historical issues, because of abuse of the African-American community by the medical establishment, and that has led to vaccine hesitancy. And that has borne out often sort of year after year with flu vaccine and other vaccine coverage rates.

It's been a different story with COVID, right? Like when you look at the longitudinal data from the Kaiser Family Foundation as one example, what you see is that from December to March, you actually see significantly waning vaccine hesitancy.

I mean, like people in Black and Latino - Black and Latino adults are moving from the wait and see or not sure category, to the already got it, or will get it as soon as I can, category. And that's been really marked, I mean, almost a 20% differential there.

So, the national survey data is reassuring that many of those minority segments of our community, it's less about hesitancy and more about access there. In other communities, large - like because of the politicization of everything COVID and certainly of mask wearing and vaccination, it's a different approach.

And there's a national foundation called the de Beaumont Foundation, and it's

worth looking at. They've done some really extensive research, some really helpful focus groups on what in rural conservative leaning, you know, people who identify as evangelical Christians, that's the segment of the population where we do see the most resistance.

So, it's the high - about 40% of that community are saying that they won't get vaccinated at any point. And so, it's a different set of tactics. It's really creating opportunities to listen well, to hear what people's hesitations or resistances are about.

It's ensuring that you're not taking a judgment stance, but really using trusted leaders in those communities, whether they're physicians or teachers or pastors, finding those voices who are compelled by the data or by the social imperative to do this, to protect your community, and can vouch for the effectiveness of vaccine.

And so, it's hard work. I mean, this - like trying to find those individuals, to give them platforms, to network through those relationships, it's hard and slow work. And so, I anticipate, you know, we got to, you know, 57% of the eligible population in four months. It's going to be really tough to chip away at that last 10 to 15%. I think that's probably going to take us another three to four months.

James Jarvis: Thank you, doctor.

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

Brett Hall: Thank you very much. Hello, Dr. Avula. My question is, and apologies if you already mentioned this, I got on a little late, fashionably late, but is there a timetable now where we're looking to shut down the mass vaccination sites

and transfer vaccine over to doctors' offices? Because I know over the months that we've been doing these Friday meetups, you talked about how some people might not be comfortable getting the vaccine until it's from their longtime doctor.

Dr. Danny Avula: Yes, that's right, Brett. So, yes, there is a timetable and, you know, we can extend the timetable if the demand is still there. But most of the large-scale centers will start to wind down between - I think Danville is slated to end the first week of May. And then - so we just opened up some in the last couple of weeks. And so, those will extend into mid-June.

And at any point, if demand is still really strong or, you know, we're working through second doses, we can continue those. So, there's no real concern for them going away before they've maxed out their usefulness. But in the meantime, we will also be transitioning more and more vaccines to primary care providers.

And one of the things I've mentioned earlier is that, you know, at the beginning of this effort, primary care providers were clamoring for vaccines, just like everybody. They wanted to serve their patients. They knew that they had a critical role because some of those patients who were potentially hesitant, were - you know, would best be served through their doctors.

But because there was such a - like such as a constraint on supply, and the imperative to get as many people vaccinated as quickly as possible, was there and was real, we moved more vaccine through these large sites. Now, as we're into this more questioning or deliberating population, this is the time to shift more vaccine to primary care providers.

There's a couple of things we've got to do there. One is shift the messaging,

right? So, up until recently, the messaging was always, if you're receiving a vaccine, you've got to be able to use it all in a week. That's not really an issue anymore.

And so, providers, you know, just need to hear from us over and over that - and get comfortable with the idea that they can get vaccine and hold on to it for a couple of weeks, or take as long as they need to work through it, provided that it's stored correctly.

The second thing is that we've got to make the logistics of vaccine distribution a little bit more provider friendly. Pfizer, as probably the biggest example, comes in 1,170 dose shipments. We are identifying local pharmacies, independent pharmacies, health departments, that are willing to receive that vaccine, and then redistribute smaller amounts, right, because we know - and I'm thinking a lot about this with pediatricians.

You know, they're going to say, hey, we can't really use 100 doses in a week at this point, or whatever the number is. We're a small practice and we really only need two vials. So, I think those are the kinds of things that we've got to work through logistically, to ensure that providers can get manageable doses that they can actually use in a given timeframe.

Brett Hall: All right. And another - this is more of a technical question. I know in our viewing area where we have several large municipalities bordering the North Carolina border, a lot of people went down there to get the vaccine. So, is there the chance that there's a lot more Virginians vaccinated that you'll ever be able to tangibly count? I mean, in interest of full disclosure, just because if a flu vaccine vial was opened, I'm one of them that was vaccinated in North Carolina.

Dr. Danny Avula: Traitor. I'm just kidding. You know, the CDC actually has - they have numbers, because all of the State immunization registries, feed up to the national immunization registry. And so, the CDC actually does provide numbers of Virginia residents that are vaccinated elsewhere.

And then we have in our database, the number of people who were vaccinated in Virginia, but don't have a Virginia address. And surprisingly, the numbers are actually not that far off. I think I told you this a couple of days ago. There was 110,000 folks who were - 110,000 Virginians who were vaccinated out of State, and then 108,000 people who we vaccinated that were not Virginia residents.

So, it really is kind of a wash. And I - and at this point, it's not a concern for us, right? The demand is exceeding - sorry, supply is exceeding demand. We want to absolutely make things as convenient as possible for anyone who wants to get vaccinated.

You know, while we're encouraging like everybody to get vaccinated in their place of residence, it really doesn't matter at this point. And we're asking providers to vaccinate anybody who shows up, regardless of their place of residence.

Brett Hall: Yes. I was just looking at the - when we talked - I was more asking in the guide to the 75% herd immunity goal, but I get you. Thank you.

Dr. Danny Avula: Yes. Maybe one more thing on that. Those numbers - I guess if we were like going to really do it to the letter of the law for Virginia, we would add the Virginians - so for the CDC database, we would add the Virginians who were vaccinated elsewhere. We would subtract out the Virginians who were - or

the people who were vaccinated in Virginia, who aren't Virginia residents. And then we would also add the doses that were administered federally.

If you do go to our Web site, you can see that there's a tab that says federal doses, and that actually shows - I think it updates a weekly, but it actually shows the total number of doses that the federal government administered to Virginia residents.

So, through the Bureau of Prisons, through the Department Of Defense, through the VA hospital system, there's about 320,000 doses that have been administered federally. And so, we don't have a lot of insight. The federal government has not been very willing to share, you know, who those people are, where they live.

And so, that has real implications for communities like Arlington and Alexandria and Fairfax County, or the Tidewater area, or I think it's Isle of Wight, wherever Fort Lee is, down in the Crater Health District. But those are places that probably have much higher vaccination rates than we're able to report because we just don't have the data, but we suspect they have higher vaccination rates because they have a large number of federal employees.

Brett Hall: All right. Thank you.

Coordinator: Our next question comes from Tom Lappas from Henrico Citizen.

Tom Lappas: Hi, Danny. Just wondering if VDH or any State entity has done any type of a survey of Virginians to kind of gauge the interest in vaccinations, particularly among those people who haven't gotten vaccinated yet. Is there, you know, one or two factors? I know you've touched on a few here, but do you have concrete data that says, hey, you know, once these vaccines earn full approval,

you know, we think X percentage of people are going to step up and take them then?

Dr. Danny Avula: So, not related to that specific issue, Tom, that issue of like approved - or maybe I misunderstood. Are you saying once they go from EUA to full approval, would that make them feel more comfortable about getting vaccinated? I don't know that we're asking that question.

VCU is conducting a statewide survey for us right now, and they're doing it in different layers. So, we are really getting at that vaccine hesitancy question. It'll probably be a couple of weeks before we have more granular answers from it.

Tom Lappas: Got you. Thank you. And then as far as ordering doses from the federal government, do you expect to be ordering fewer doses? Are you going to stay at the current numbers for a little while longer since you can kind of stock up, I guess, in some way, but what does that look like going forward?

Dr. Danny Avula: Yes. I mean, the concern about ordering doses that we don't use is that there's a limited lifespan, right? And so, we wouldn't want to order down doses that will potentially expire if they're not being used. We will - I mean, we basically every week, just send out to all the providers what our total allocation is, and we ask them to submit orders, and then we order down whatever they need.

This was the first week that that hasn't been all the doses that we asked for. So, I anticipate that will continue to be the case over the next few weeks. We may see a blip when the 12 and up gets approved, at least for the Pfizer. But yes, I don't think we would order and stockpile vaccine, unless we really could anticipate demand or figure out how to generate the demand.

Tom Lappas: Thank you.

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

Coordinator: Our last question comes from Leanna Scachetti from WDBJ7.

Leanna Scachetti: Hey, Dr. Avula. Real quick question. You touched on this a little bit earlier, but what is the latest statistics that you have for vaccination of college students? I know a lot of them are rapidly approaching graduation, and I know you'd wanted to get to them before that. And then if you have time to answer, we're under EUA for those vaccines right now. How quickly might we see full approval from the FDA? What would that take?

Dr. Danny Avula: For, the second question, I don't really know. I mean, I've heard the question asked in other forums, and people say it'll probably be a year before we move from EUA to full licensure with the FDA. But not a super clear timeframe on that. The FDA has been pretty open-ended in the way they've answered that.

The first question, I don't have numbers on college students. I mean, we were doing a lot of planning, particularly prior to the J&J pause, on college and university vaccinations. We were really prioritizing J&J for that population. And when - and how to schedule, have all of those events scheduled out so that people could be fully protected prior to graduations, and that people could at least get vaccinated before they were leaving after exams.

So I would have to do - I would have to go back and figure out, like of all of the events that have taken place - and some of those events are still taking

place, right? We have colleges and universities that are still in session and have vaccination events that are set up for next week and the following week. And especially those who switched over, which is most of them, switched over to two-dose vaccines, they've got their second doses coming towards the middle of May.

So, I don't have total numbers yet. I think probably in a couple of weeks, we'll be able to aggregate all of the college students who were vaccinated through all of these different events. But, I don't know, just kind of anecdotally, there were definitely some schools that were either small enough or didn't anticipate demand.

And so, we're not really planning on doing anything on campus. But probably 75% of the schools did host, or channel their students to an existing vaccination event, because we had a lot of situations where, for example, in Norfolk, you had a large, you know, federal community vaccination center and many schools in the radius that could just send their students and faculty over there. So, all - we'll work on that. Like I said, it'll be a couple of weeks before we have good numbers on that.

Leanna Scachetti: Thank you.

Coordinator: We have no additional questions in the queue at this time.

Melissa Gordon: I want to thank everybody for joining our call today. There will be an audio recording posted on the VDH Web site, 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 for your participation in today's conference. You may disconnect at this time.

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