

**Virginia Department of Health Tele-Press Conference on
Virginia's COVID-19 Vaccine Developments
Moderator: Melissa Gordon
May 13, 2021, 10:00 am**

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 or good morning. And thank you for joining the 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 and Virginia Department of Education Superintendent of Public Instruction Dr. James Lane. They 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.

I have a brief announcement before we begin. VDH will perform plan maintenance on the servers supporting VDH COVID-19 dashboards starting Friday night 5/14/21 and continuing through Saturday, 5/15/21.

To make sure the COVID-19 data remains available, VDH will post static images of these dashboards during the maintenance. If you need to review, the COVID dashboard on a mobile device or tablet, the formatting may look different.

VDH recommends viewing these images on a laptop or desktop computer during this time. This will not impact the COVID-19 datasets, which will continue to be available for direct viewing or download through the Virginia open data portal.

I'd like to welcome Dr. Avula to share a brief update.

Dr. Danny Avula: Thanks, Melissa. And good morning, everybody. We continue to march forward towards community immunity here in the Commonwealth of Virginia, just over 6.9 million doses administered as we frame our goal in light of the President's recent announcement to getting to 70% of adults by July 4 with at least one dose.

We continue to make really good progress that way. We're right at about 64% when we frame things in terms of that metric.

But we know that getting to community immunity means that we have to vaccinate more than just the 18 and up population. And so we've had some really exciting news over the last 24 hours that are going to allow us to get more and more people vaccinated to really defend against any opportunity for COVID to continue to have a hold in our communities.

And so as you all know by now, the FDA Monday evening gave approval for the Pfizer vaccine to be used on ages 12 to 15. Yesterday the Advisory Committee on Immunization Practice met at around 3:30 and voted 14 in favor, 0 against and 1 abstained to adopt - or affirm that recommendation that we should use Pfizer in 12 to 15.

Shortly after that the CDC director adopted the Advisory Committee's recommendation as well and within an hour of the CDC approval our Virginia Department of Health team affirmed that for providers as well.

So a press release went out last night saying that we can now vaccinate 12 and ups with Pfizer in Virginia and messaging went out to all of our approved vaccinators.

And so maybe you started last night. But likely today we will see 12 years old - 12 and ups get the opportunity to receive that important protection.

I think a lot of questions that we've received around, you know, why? Why should we be vaccinating adolescents, especially given the reality that the vast majority of young people who get vaccinated - sorry, the young people who get COVID get very mild disease, about 25% to 40% of that population actually gets asymptomatic. You know, they don't actually develop symptoms.

But they still do get COVID and the fact that they get asymptomatic or mild disease in some ways makes it more possible for them to spread COVID. And we've certainly seen this in surges and outbreaks around the country, especially now that we have so much of our adult population vaccinated.

We have seen young people really driving spread in communities. And so when you look at over the last few weeks what's happened in the Midwest, for example, it was high school students and college students that were driving transmission.

And while they were not, again, suffering severe consequences of COVID, that led to the highest rates of hospitalization in 30 and 40 year olds that those states have seen at any point.

And so there is to some degree an individual benefit for kids to be protected against COVID. You know, while rare there are some who get hospitalized and then some who develop this very rare condition, the multi-inflammatory syndrome in children. There's been about 3,000 documented cases of that.

So there are serious things that we want to protect against. So there's an individual benefit. There's also clearly a community benefit because as adolescents are vaccinated, it decreases the ability for them to contract COVID and to spread COVID.

And then there are really practical benefits. And, you know, as we think about getting back to normal, as we think about getting kids back in school in some sort of normal format, the reality that fully vaccinated people do not need to be quarantined after an exposure is a really great benefit, right?

The fact that they don't have to be out of school for 7 to 14 days. The fact that they don't have to be, you know, out of sports teams or games for 7 to 14 days, all of those provide really practical benefits.

And so I hope that our communities will see that, will be encouraged by that and that students and their families really do take the step to get vaccinated for themselves and for their communities.

There will be multiple opportunities for kids and their families to do this. Obviously all of the existing pathways to get vaccinated are now in play and will now be open to 12 and up. So going to pharmacies, going to providers who carry the vaccine, going to Health Department clinics.

And then there's been a lot of work over the last few weeks in anticipation of this to really connect with local schools because we know that working through schools is our most effective way to get information out and to really get access to this segment of our community. And so the school systems have been wonderful partners.

You know, we've already been doing school-based vaccination for the 16 and 17 and 18 year old populations that are still in school and now we will be able to extend that to the 12 and ups.

So with us today, we have Dr. James Lane. I really appreciate you being here, James, just to talk about, you know, what you see from the school perspective.

Dr. James Lane: Thank you, Dr. Avula. And just adding to his comments, I will share we met with superintendents earlier this week to begin briefing them in advance of the approval of the vaccines for 12 to 15 year olds.

I heard from many our superintendents that they were excited about that. Many already had clinics scheduled for 16 to 18 years olds and notified us that they would be able to add 12 to 15 year old' at those clinics that were already scheduled once approval came through, which obviously has now happened.

The school divisions - we are encouraging the school divisions to host vaccination clinics if they can in partnership with either pharmacies or their local Departments of Health.

Many students may not have transportation to go to pharmacies or other places that are offering it. And so the school is an efficient means for families to be able to access the vaccine.

Parents will have to give permission. So it will be important that our schools are prepared and have permission forms for parents to sign. But when vaccines are done in schools with parent permission, a parent does not necessarily have to be present. So it can also be more efficient for families to get students access to the vaccine.

So obviously getting our students vaccinated like we got our teachers vaccinated is an important step to getting back to the five days a week every day open school situation that we all know will happen in the fall of this year.

Obviously this is another strategy that we need to put in place to build that confidence that will be necessary to have all of our families choosing to come back in addition to having all of our schools open as required under the law in the fall.

So we are excited about this opportunity. Obviously, you know, there are no specific requirements that anyone get vaccinated. But our schools are going to do a great job of explaining the benefits of vaccinations and providing opportunities for families to do so.

So happy to answer any more questions that we have related to schools. And Dr. Avula gave a lot of great information about the benefits of youth vaccines. And so with that, I'll turn it back to Melissa.

Melissa Gordon: Thank you for that update, Dr. Lane. Before we begin our 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 will begin the question-and-answer portion of today's call. Operator?

Coordinator: Thank you. If you would like to ask a question, please press star 1. If you need to withdraw your question, press star 2. Our first question comes from Amie Knowles from The Dogwood.

Amie Knowles: Hey, Dr. Lane. Hey, Dr. Avula. Thanks for taking our questions. The first one is for Dr. Lane. I was wondering at schools who is going to administer these vaccines. Will school nurses administer the shots during, like, the school day or will local VDHs come in and host clinics or things like that?

Dr. James Lane: It frankly will depend on the locality. But in most of our localities they will not be establishing themselves as the CDC site. They will instead partner with the local Department of Health as a host site for the vaccination clinic.

And therefore, it will most likely be those individuals that have already been approved to be vaccinators through their Department of Health in that locality.

Amie Knowles: And then, Dr. Avula, how does the vaccine for 12 to 15 year olds compare to the one for (unintelligible)? Is there any - it's like do they get a diluted dose or a lesser amount of vaccine or is it exactly the same?

Dr. Danny Avula: Yes, Amie, hey. You cut out a little bit. I think the question was, is the dosing the same? Is it the same exact vaccine for adolescents that adults are getting, is that right?

Amie Knowles: Yes, sir. That is correct. Thank you.

Dr. Danny Avula: Yes, it is. You know, all the clinical trials that were done for the 12 to 15 population were done with the same dose, the same mix, the same ratio as what adults are receiving.

And that's actually why this was able to happen so quickly. You know, the clinical trials and the really compelling data from those trials. So I'll just maybe take a second to talk about that.

About 2,000 teenagers, aged 12 to 15, participated in the trials in what they saw was in the placebo group of 970 some odd people, there were a total of 16 confirmed cases of COVID.

And then in the vaccine group, which was a little bit over a 1,000 individuals, 0 cases of COVID. So Pfizer is reporting 100% efficacy with that population.

I think the reality is that when we go from testing - you know, from clinical trials on a couple thousand to administration to millions we will likely see some breakthrough cases. But I expect that those numbers will be very, very low.

And then one other addition to that is a lot of people have asked about, okay, well, now that we have adolescents, what about younger children? And we do absolutely expect, like, with most medications that there is a shift in dosing when we get to that smaller end of the age range.

And so one of the reasons the clinical trials are taking much longer with the, you know, six month and up population is because they've got to figure out what are the right dosing amounts for the different age ranges.

And so at this point, you know, it could be as early as September at least for the 2 and up but likely will be later into the fall or early into the winter, early 2022 for a vaccination down to that 6 month or 2 year old age range.

Coordinator: Our next question comes from Caleb Perhne with WCYB.

Caleb Perhne: Hello, Dr. Avula. I wanted to ask you about - I've seen on some of the national publications, particularly the New York Times, that some health experts were thinking that at some point it might end up that we not reach herd immunity.

It sounds like you think that we will in Virginia. But I wanted to ask about, you know, here in rural Southwest Virginia where the vaccination rates are lower. I think it's like 30% to 40% first dose on the whole population.

What kind of strategies are you guys using to try to get us to that level?

Dr. Danny Avula: Thanks, Caleb. I'll maybe talk a little bit about the concept of herd immunity first and then talk specifically about what's going on in Southwest Virginia.

You know, the idea of herd immunity or community immunity, the idea that we're trying to get as many people protected against COVID so that if COVID

were to be introduced to a community there wouldn't be that many available hosts. We wouldn't see large scale transmission. We wouldn't see outbreaks occurring.

And so the idea behind herd immunity is to maximize the number of people who are protected.

Now we don't know what that magic number is. We do know that based on the contagiousness of COVID that it's likely between 70% and 80%. You know, some diseases that are more contagious than COVID, like measles for example, you probably need to get to 90% to 95% of a community to reach herd immunity.

But given the transmissibility of COVID, we've put that somewhere between 70% and 80%, which is why, at Virginia, we kind of from the beginning of this said our goal was to get to 75% of the population.

Now, you know, what I started off with was us being able to get to the President's goal of 70% of adults with one dose by July 4. I think we are very much on track to do that.

I do think it's also very much within reach that we get to 75% at least of the eligible population and that immunity doesn't only come from vaccination although that's our preferred route, both because it avoids people getting sick but also because what we've seen so far is immunity generated by the vaccine is actually much more robust than natural immunity from the virus itself.

And so all that to say that we will get to community immunity through a combination of vaccination and through people contracting COVID.

Remember there's 600 some odd thousand Virginians who have actually contracted the disease and have varying degrees of natural immunity.

Now to what's happening in the Southwest. You're right, there initially has been much lower uptake than in other parts of the state. And I've been incredibly impressed with the efforts of our local Health Departments and so many other partners.

I mean, when you think about innovative ways to get to people, they're doing them all. They're going and doing pop-up vaccinations in bars, on college campuses. They have people, roving communities and steering them towards pop-up efforts.

There's a great example in Roanoke I heard about the other day where at a grocery store there's a pop-up vaccination site.

And AmeriCorps volunteers are actually helping people take their groceries to their car. And in that couple of minutes of conversation say, hey. Have you thought about getting vaccinated? If so, you can do that here today.

So there really are so many different efforts to make vaccine more accessible, to engage people on the reasons why they don't want to be vaccinated.

We do know that, you know, so much of the - you know, the process of people making a decision about this to some degree is about the head, right? Like what does the data say about (who should vaccinate)? But it's much more about the heart.

And so I think having the opportunity to really talk through this with somebody who is not going to judge you, who is not going to shame you but

will really give you straightforward information is a really important part of this phase of the vaccination.

And so that's why so much effort is being put into right now to shift vaccine availability into primary care providers in the pediatricians' offices, into family practice offices. Because patients are going to want that degree of engagement with their provider.

They're going to want somebody they trust to tell them whether they should do this or not.

So those are kind of some of the key strategies we're using. How do we lower barriers to access by making it more convenient and more accessible through all of the pop-up and mobile and, you know, community-based vaccination and then shifting more and more vaccine to private providers so that they can play a really key role in helping their patients understand the value and the importance of this.

Maybe one thing I would add to that Caleb is that we look at rates in places like that and I think we immediately jump to, hey, if we only have 40% covered that means 50% don't want to.

I think what we're seeing all over the country is that it's not that that 60% is resistant or that they don't want to be vaccinated. It's just that, you know, it hasn't been front of mind for them.

And so I do think that all of these types of efforts to really make it convenient and to get out to where people are going to help us move towards community immunity.

Caleb Perhne: Thank you.

Coordinator: Our next question comes from Kate Masters from the Virginia Mercury.

Kate Masters: Thanks so much. These questions might be for Dr. Lane. But my first one was just whether there had been any school districts who have been resistant to the idea of vaccinating students or holding, you know, these in-school clinics in the way that you were kind of suggesting with some of your first statements.

Dr. James Lane: I have not heard that. But I do know that there are some communities where the partnerships at the local Health Department or the partnerships with pharmacies and the numbers of students in those communities might be so low where a school-based clinic might be unnecessary because there are other places to get it and ways to make that happen.

But I've not heard from anyone who said that they just don't want to do it. I think everyone is looking to provide families that are interested in having their children vaccinated an option that I've talked to.

Kate Masters: Okay. And then my second question was, you know, obviously there is no mandate to get vaccinated or for students to get vaccinated against COVID-19 now.

But I'm wondering if that is sort of a tool in the arsenal for VDOE. I'm looking towards the future. And if not, what makes the COVID-19 vaccine different from, you know, mumps and rubella and all the other sort of routine immunizations that students are mandated to get in Virginia schools?

Dr. James Lane: That's not a decision that's within the authority of the Virginia Department of Education. I believe that the governor said recently said that that's under the authority of the General Assembly.

And so, you know, obviously we're going to operate until such time as there's a change there as if it's not required.

Kate Masters: Great. Thank you.

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

Taylor Coleman: Hi, Dr. Avula. According to the vaccination dashboard here in Lynchburg, we lag behind several larger surrounding counties and really just to say average in the percent of the population who has received at least one dose of the vaccine.

Do you know why larger cities like Lynchburg, why they might be lagging behind and what can really be done to kind of raise that percentage?

Dr. Danny Avula: That's a good question, Taylor. I mean, as we look at those unique cases where we would expect to see higher rates, I think there are a lot of dynamics at play.

You know, the national data would certainly suggest that, you know, people in more rural communities have lower uptake. People who identify as either conservative or, you know, I've seen surveys that have said Evangelical Christians have much higher rates of vaccine resistance.

And, you know, I think that points to circulating concerns or adoption of information that just isn't always true. And so some of our work - you know, this phase of vaccination, right, the last four months have been all about make vaccine available, right?

Figure out how to divvy it up across the state. How to get it to the places where we can get vaccine out to the communities who need it most, who are the most vulnerable and then in a fair way based on population around the state, really focusing on large scale efforts to try to get as many people vaccinated as quickly as possible.

We are clearly at a different phase of this. And so much of the work now is in our messaging, our community engagement, how are we creating opportunities and venues for people to really face this information and ultimately make the personal decision about whether they're going to get vaccinated or not.

We know that for some people the prospect of protecting themselves is motivation enough. For others, it's protecting your community. For others it's the momentum to actually get back to normal, so to, you know, move on from these restrictions and mandates and to prevent the prospect of this happening again.

And so in all of our on the ground outreach efforts with our community health workers, with outreach specialists, with the work that the local Health Departments and our health provider partners are doing, those are the kinds of messages that people are going to need to hear.

And we've got to find more ways - and I spoke to this earlier with Caleb's question, for people to actually be able to have a trusted source of credible

information so that when misinformation comes up, like, hey, is there a microchip in this vaccine? Or, you know, will getting vaccinated make me infertile? That you have somebody who can intelligently speak to those concerns with real information.

So, you know, I think the dual strategy of both relying on trusted voices, trusted leaders in communities to be ambassadors for this but then also ensuring that credible experts, physicians and other health care providers can engage residents in those conversations.

Taylor Coleman: Thank you. And I know you touched herd immunity earlier. But can you kind of elaborate how close we are to herd immunity in Virginia and what can be done to kind of accelerate that?

Dr. Danny Avula: Yes. I mean, I think there's a couple of layers to it, right? So there are goals that we set based on who can actually be vaccinated. And so up until yesterday that was 16 and up.

And we had aligned a lot of our public communication to the President's goal. So the President's goal was 17% of adults, 18 and up, with one dose by July 4.

Our numbers as of yesterday was 64% of adults 18 and up with at least one dose. So certainly within reach and I think we will get to that Presidential goal by 70% by July 4.

Epidemiologically, what we're looking at is trying to get to somewhere between 70% and 80% of the entire community of people who can get COVID to get them protected. And that's going to happen, you know, largely through vaccination and then to a lesser degree through natural immunity that is developed in response to actually contracting the COVID virus.

And, you know, those numbers, because they're such a large part of our population that hasn't been eligible to be vaccinated, right? So when you look at our dashboard, you see the daily updates. We're just shy of 48% of our total population today that's been vaccinated with at least one dose.

So, you know, we're making steady progress. Obviously today's announcement or yesterday's announcement that we are now able to vaccinate 12 to 15s adds another 420,000 Virginians who are eligible to be vaccinated.

We've seen a pretty encouraging response. I mean, there are people lining up all over the place today to get their teenagers vaccinated.

In a survey that our VCU partners did this past week, we saw somewhere around 60%, a little north of 60% of parents said that they would get their teenagers vaccinated.

So I think, yes, all that to say, I think we are very much, you know, that herd immunity goal, that 70% to 80%, is very much within reach through the combination of vaccination and those who have contracted COVID.

Taylor Coleman: Thank you.

Coordinator: Our next question comes from Adriana De Alba, WVEC.

Adriana De Alba: Yes. Good morning. My question is are you still coming across people who don't get their second dose? And if so, what is your message to these people? Why is it so critical that they get that second dose and become fully vaccinated?

Dr. Danny Avula: That's a great question, Adriana. Thanks for that. I mean, we pulled the data yesterday. And we look at it on a weekly or so basis of what percentage of people who have gotten their first dose but have not gotten their second dose within the CDC recommended six week period, 42 days.

So yesterday that was 6.7%. So 6.7% of people who have gotten a first dose have not gotten their second dose within the recommended time period.

It is concerning because not only do we want everybody to have maximum protection. That's good for individuals. It's good for communities. But we are starting to see some initial data about first dose versus second dose effectiveness against some of the variants.

And this is - trust me. Because variants are clearly here in the United States, here in Virginia.

The CDC has reported that 66% of the new cases in the United States right now are the B117 variant, which is the UK variant. And then there's another 10% or so that is the P1 variant out of Brazil and then 3%, that is the South African variant, the B1351.

And so what we've seen - one of the initial studies that was reported in the New England Journal of Medicine last week what was that there was a big differential between one dose protection and two dose protection that is much more disparate than we've seen with the typical COVID strains.

And so you go from, you know, north of 80% effectiveness against these variants to more like 20% effectiveness with just one dose.

So that need to get people fully protected and to make sure that people come back and get their second dose is really significant both to ensure that individuals are protected but also to ensure that a new variant, like we're seeing in India right now, doesn't present a huge new threat to us.

So, I guess the other part of the question was, what are we doing about that? We've really shifted our messaging to providers over the last couple of weeks. You know, for the first four months, we really encouraged everybody who got a first dose to go back to that place to get your second dose.

The reason we were doing that is because of the way the vaccine was being distributed by the federal government, those second doses were attached to first dose orders.

And so in a scarce supply environment, it was going to be most clear and most straightforward to be able - because if you're a provider and you have first doses, you will get the second doses.

But now we're in a really different stage because we have plenty of supply. And so we've asked all providers to not worry about where people got their first doses but to really make second doses available.

And so the more flexible we are, the more accessible we are. We hope that that will increase people's access and just increase their ease to get that second dose.

And then in addition to that, to message stuff like this to really help people understand why that second dose is so important and the prospective threat of variants and, you know, that being even more a sense of urgency to ensure we get those second doses in.

Coordinator: Our next question comes from Heather Graf from WJLA.

Heather Graf: Hi. Good morning, Dr. Avula and Dr. Lane. Thanks for doing this. I was curious, with 12 to 15 year olds now eligible, do you see that as possibly an opportunity to vaccinate parents who maybe didn't get the vaccine previously because their kids couldn't get it?

I'm just curious what you think that impact might be. You know, now that adolescents are eligible, could that impact more adults who are parents of adolescents?

Dr. Danny Avula: I absolutely do. I mean, I think I've got two of my five kids are in that age range. And they are very vocal about how they feel about things.

And, you know, I think there are other examples of where teenagers have led the charge. I mean, when you think about things like recycling or, you know, environmental awareness.

The things that kids are being exposed to, you know, they're really powerful movers of their families.

And so I absolutely think adolescents who have lived through this, who want to get back to school, who want to get back to school without restrictions, that that motivation will open some doors for parents who are maybe not sure or just haven't made the appointment but now this will be an opportunity for them to get vaccinated as well.

No idea what kind of scale that will be. But I do think we'll pick up a number of adults who are supporting their kids and getting vaccinated.

Heather Graf: And just as a follow-up, would school systems or Virginia Department of Health be able - you know, how would they try to capitalize on that opportunity in terms of outreach to parents?

Dr. James Lane: Well from the school side, certainly our school divisions will be putting together information to send home to families about the availability of the vaccination clinics, the benefits of being vaccinated.

And certainly, I think anytime we're communicating about vaccines, we try to provide all of the options that might be available to families.

Heather Graf: Thank you so much.

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

Sabrina Moreno: Hi. Thank you so much. So we've seen inequities, you know, laid bare throughout the pandemic. That's continued in the vaccination rollout.

And I wonder what is VDH's plan to, you know, address how these challenges could be more pronounced in children of essential workers and immigrant parents?

Dr. Danny Avula: I think, Sabrina, I think that's so much of the impetus behind school-based vaccinations both because kids are in school. And so we'll have more reach, more ability to get information to students and their families through schools but also the practical reality of, you know, many of our non-English speaking families or, you know, minority families that work night jobs or that aren't as available if they're working multiple jobs that having the opportunity to get

vaccinated in schools without the need for a parent to actually be present onsite will really improve our uptick rates.

And so we very much talked about school-based vaccination as part of our racial equity strategy in this population.

So, yes, just know that's been a big part of our discussion and our hope. Yes, I think we'll have to continue working with our teams and with our outreach folks on how do we get to adolescents in this demographic so that we can keep pace with the rest of the population.

Sabrina Moreno: You know, with plans to lift all restrictions on June 15, but there are still being, you know, CDC guidelines on what schools might do, what has the state determined, you know, the level of cases, hospitalizations or vaccinations among kids kind of needed to lift the mask mandate, you know, upon reopening in schools in Virginia?

Dr. Danny Avula: I don't know that we have a specific number. I mean, pediatric hospitalizations have been such a small part of the overall pie.

I do expect that, you know, in this kind of interim period where we're vaccinating so many adults, we are going to see higher rates of young adults or pediatric hospitalization just because that's who is remaining.

And so if we see the reintroduction of COVID, those who are vaccinated are going to be protected and we will potentially see higher rates of hospitalization in adolescents or younger pediatric population.

But that's not happening right now. So, like, our decision to move towards reopening on June 15 really continues to track with what does our vaccination

rate look like, what is personal positivity and what are our overall rates of hospitalization, which all right now we're trending in the right direction.

Coordinator: Our next question comes from Julie Carey with NBC4.

Julie Carey: Good morning, Dr. Avula. We are hearing from a couple of our clinics here, the one in Tysons and the one at Gander Mountain, that parents with 12 to 15 year olds are being turned away today and being told that Virginia has not given them approval. Have you heard about that? Do you know what's going on?

Dr. Danny Avula: I had not heard about that specifically with Gander Mountain. I do know with our CVCs, so the community vaccination centers, there's about nine throughout the state. Gander Mountain is one of those. We had made the decision to hold off until Friday for that 12 to 15 population.

The only reason being, like, all of our other providers, you know, our Health Department providers, our private providers, our pharmacies, you know, they're all doing this on a regular basis. The policies are clear.

But our CVCs, our community vaccination centers, are done with a lot of new and local hires from agencies and from other sources. And so we really just wanted a buffer to make sure that those community vaccination centers knew the policies for consenting, had folks trained and ready to go and knew how to address some of the questions that may come up with parents.

And so we had made the decision that CVCs, in particular, that one channel would hold off until Friday.

That went out to different news outlets early this morning or yesterday evening. But they should be up and running tomorrow and hopefully that doesn't cause too much frustration for parents who were trying to get out there today.

Julie Carey: And is Tysons not also one of those types of clinics? I thought they were.

Dr. Danny Avula: No. It is, yes. So same.

Julie Carey: That's why. I guess I still don't quite understand the distinction between who is giving vaccinations in other clinics and why that would be different at those clinics.

Dr. Danny Avula: Okay. So if you're in Inova Health Center, you have your own nurses that know the protocols. They know the organizational policies and they're well practiced in this, right?

And so even in a changing environment - so for example, with us at VDH, we just have defaulted to our standard policies for minors getting vaccinated that we need a parental consent or a consent from a parent or a guardian or someone standing in lieu of a parent and we have that mapped out.

We had it mapped out for school age settings. We have it mapped out for our Health Department clinic settings. Because these community vaccination centers aren't kind of existing organizations with institutional memories and policies, we just wanted to make sure that given the late adoption of this yesterday afternoon that we really knew all of the - like could anticipate all of the questions that would come up and had those, you know, largely temporary employees who were employed into these CVCs trained and ready to go so that they could answer those.

So, for example, you know, one of the additions that the ACIP voted on yesterday was about co-administration. This idea that prior to yesterday the guidance was that COVID vaccinations should not happen within two weeks of other vaccines being received by children.

But after the Advisory Committee reviewed that information - I'm sorry reviewed the data around adolescent vaccination, they said it is okay to co-administer.

So, you know, that's a significant change. And it's something that providers should be ready to answer for parents who ask.

So it's things like that that because all of this came through around 6:00 p.m. yesterday, we just wanted a little bit of a buffer for a lot of these new and temporary employees to train them and make sure that we can safely administer to folks who are showing up.

Julie Carey: Thank you.

Coordinator: Our next question comes from Stephanie Harris from WAVY TV.

Stephanie Harris: Good morning. Thank you. Actually, I want to follow-up on what you just said about that change. So is there any time frame now that they need to hold off between other vaccines?

I know it was the two weeks. So if you had the Pfizer, you were basically seven weeks out between any vaccines. But is there any time now?

Dr. Danny Avula: No. The ACIP guidance is that COVID vaccines can be co-administered with other vaccines.

So the only caveat really is that private providers should think about what are the other vaccines that need to be administered based on, you know, where they are in their schedule.

And then there was a notation in the ACIP guidance around considerations for the reactogenicity of a vaccine, meaning every time a child or anybody gets vaccinated, what's happening is you're eliciting a response from your immune system. You're revving up your immune system to create antibodies to protect against an intruder.

That happens to varying degrees with varying vaccines. And so if there are a number of vaccines that a child needs that are considered reactogenic, the provider may make a decision to say, hey, let's space this out a little bit.

But no definitive guidance around that. And really the big shift is that they can be administered with other vaccines without any interval in between.

Stephanie Harris: Okay. Great. Thanks. So the original question I was going to ask is kind of about the herd immunity again. And now that we're able to add 12 year olds and up into this, how might this play into loosening mask rules and things like that?

You mentioned momentum to move on is a big, you know, driver for a lot of people to get this. And I think some people are feeling a little bit defeated.

Like, all right. I've been fully vaccinated for a month or for two months. And I still have to walk around with this mask. And then their kids see that or other

people are talking about it. And it may be hindering people from getting the shots.

Dr. Danny Avula: Well, I think some of that loosening has already happened, right? I mean, I think the CDC has been really good about adopting new evidence into its guidelines.

What was it two weeks ago, I guess, the CDC came out with new guidance around folks who are fully vaccinated no longer need to wear a mask in outdoor settings unless it's a very crowded, you know, concert or sporting event.

But by and large, fully vaccinated folks don't need to wear masks outside anymore. And then there are increasingly scenarios where indoors people don't need to wear masks.

But while we still have such a large portion of the population that is not vaccinated and while we still have circulating disease, you know, while rates are really good, we're still seeing 500 to 600 cases of COVID a day throughout the state. And we have this looming threat of variants so we are going to continue to follow the CDC recommendations.

And so I guess maybe the direct answer to your question is we've already seen evidence that CDC has moved its guidance based on what we know about vaccination and we'll continue doing so the more people that get vaccinated and the less disease we see.

So it should be an incentive to everybody to get as much of our population vaccinated as possible so that we can tamp down the spread of COVID and get back to, you know, non-mask wearing normal life.

Stephanie Harris: I guess there's just no magic number yet.

Dr. Danny Avula: Right. That's right.

Stephanie Harris: Thank you.

Coordinator: Our next question comes from Jenna Portnoy from the Washington Post.

Jenna Portnoy: Hi, there. I'm curious if you can, Dr. Lane or Dr. Avula, quantify at all what's happening the schools. I know it's decentralized somewhat.

But do you know if, like, most school districts are making moves to vaccinate within their walls or, you know, if it tends to be more urban or suburban or rural, districts that are doing it?

Dr. James Lane: Thanks for the question. Keep in mind our superintendents only heard about this Tuesday morning and then, of course, the approval did not come through until late yesterday.

And so I cannot quantify that for you today. But, you know, we have a school nursing liaison at the Department of Ed. We've asked that team to begin looking into that so we can have a better sense of the numbers.

But just anecdotally from my conversations with superintendents, I think that all school divisions at a minimum are going to make sure that families are aware of where 12 to 15 and 16 and 18 year olds can get the vaccine.

And almost every school division I've spoken to, which certainly is not a majority of the 132 at this point, but almost every school division I've spoken to has plans to do something along the lines of having a clinic.

So, again, I can't quantify. But I have a feeling it's going to be a very large number.

Jenna Portnoy: Okay. And just to follow-up on that. I know you had a call with superintendents recently. What concerns did they have, if any, about doing this?

Dr. James Lane: I actually did not hear a lot of concerns from the superintendents. It was more logistical questions. And we addressed those. And so I did not actually hear many concerns.

Jenna Portnoy: Standardized testing, does that pose any challenges if kids simply had, you know, side effects that caused them to miss school after the vaccine.

Dr. James Lane: Certainly that's a logistical type question that was asked. And, you know, we allow plenty of flexibility with SOL testing in normal times when students are ill.

And so certainly with SOL testing if a student is not feeling well after the vaccine, we would not encourage the student be required to take the assessment at that time and wait for a time that they're feeling better.

I also encourage our school divisions, you know, if they're having a clinic for a large number of students on a given day, I would not have SOL testing, for instance, the next day for that large group of students.

And so I think our school divisions have plenty of flexibility within the SOL testing window to work with families. And, you know, should there be any reason that a student doesn't feel 100%, then they absolutely should be given flexibility to take those assessments at another time.

Jenna Portnoy: Got you. Thank you.

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

James Jarvis: Good morning, Dr. Avula and Dr. Lane. I just had a quick question about vaccine hesitancy.

Since there's been such high rates of vaccine hesitancy or higher rates of vaccine hesitancy among Evangelical Christians and people of color, low income people, will there be a point, or if it gets to a point where there's large numbers of, you know, kids in schools that aren't vaccinated because, you know, their parents are hesitant to get the vaccine and hesitant to allow their kids to get the vaccine.

I don't know if this is within your jurisdiction to answer this question, but could there be a point where school districts make it mandatory for kids in public schools to get vaccinated?

Dr. James Lane: Thanks for the question. Dr. Avula, I'll take that one if you want. I addressed that question a little earlier. That is not under the authority of the Department of Ed. It is under the - you know, it is with the General Assembly.

And so, you know, until such time as the General Assembly opines on that -- they have not -- we're going to operate under the notion that it's not required.

James Jarvis: Okay. And just to touch on the data that's been recorded by the VDH really quickly too. There's been pretty, you know, major gaps in data being collected.

And, you know, that's a problem for, you know, being able to accurately portray the issue of what kind of racial and ethnicity among other demographic data disparities that there are in the state.

And so I'm just curious about how VDH is planning on targeting certain populations such as people of color, low income people, et cetera, if they don't actually know what population - what disparities there are with greater accuracy?

Dr. Danny Avula: Yes. I think you're speaking to the specific issue of 40 some odd percent of our data doesn't have race and ethnicity attached to it.

There's a couple of ways we've approached that. One is kind of a sort of statistical estimate. So in epidemiology often what we'll do when we're trying to get more localized data is use mathematical modeling.

And so based on things like the demographics of a census tract or there's an algorithm that's widely used that attaches the last name and potential race and ethnicity attached to that to the specific demographics of the locality or census track where somebody lives, we do an imputation.

And so that's more for - we don't publish that publicly just because it's not accurate, right? I mean, it's helpful. You know, it helps us hone in what communities do we need to lean into. But because it's not based on actual data, you know, we don't put it out there.

I think the other reality is that people know - like our local health directors, our local health districts are working in these communities every day.

And, you know, when we think about the public health work on the ground and through the network of partners, we have a really good idea of where those communities are and where we need to set up pop-up vaccinations and where we need to do more engagement.

So it's not a perfect science for sure. Obviously, we'd like that data to be - we'd like to have more of that data. We actually contemplated doing call backs and just felt like not only would that be very onerous but also potentially invasive for a lot of people who had chosen not to provide that information, which is certainly the case in some percentage, not 40% but.

Yes. I don't know. I think the other piece of this is that we've work to do across every demographic, right? Like, we're not at our goal yet regardless of who you are, where you are.

So many of the strategies that we're employing we know that we're going to have to get out there, get on the streets, engage communities more effectively, work through trusted partners and make vaccine more accessible.

And so those are going to - while the messaging might be slightly different from community to community, the core of the tactics are the same.

And so I think we're in the phase for the next two to three months where that's the bedrock of what we're doing.

James Jarvis: 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 Brian Reese from WAVY Channel 10.

Brian Reese: Hey, Dr. Avula. I'm just seeing if there's an update on possible incentives for people to get the vaccine at some point, maybe monetary. I know Ohio has that lottery that they just started.

And I was wondering for a way to fund it. I know Governor Northam said he had a big surplus for tax dollars and things like that. And there's American Rescue Plan money on the way.

And I was wondering if that could possibly be used to fund that. Your thoughts?

Dr. Danny Avula: Thanks, Brian. This is a daily topic of conversation, certainly as we see more and more reports around the country of what people are using. I think there's a few different considerations, right?

One is does the state deploy resources to help incentivize people getting vaccinated? And if they do so, do they do that retroactively? And I think, you know, those have very different price tags. And so we need to think through those scenarios.

And then the other side of this is, what role does the private sector play? Many of the incentives that we've seen in states around the country, for example, New Jersey's, you know, shot and beer. You get a vaccine, you get a voucher for a beer at 1 of 40 different breweries.

A lot of places are offering, you know, gift cards or vouchers for food or Illinois, the other day, I heard a report of them having free access to the shooting range if you get a vaccine.

So there are lots of creative ideas out there. And many of our private sector partners are already doing this here in Virginia.

Certainly employers have incentivized financially their employees to get vaccinated. For example, Kroger has offered for these last few months \$100 gift card to their employees that would get vaccinated.

In Virginia Beach, I think the minor league baseball team is offering tickets to anyone who will get vaccinated. So these things are popping up all over the place.

And so, yes, we are actively considering what, if any, incentive needs to be applied? How would we pay for it? And what kind of fiscal impact would that have and at the same time can we continue to work with and encourage private sectors to be a part of that incentive solution?

James Jarvis: Thank you.

Melissa Gordon: And with that, 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 a written transcript. You will be able to access these documents at vdh.virginia.gov/coronavirus/media-room.

Once again, if we were unable to answer your questions 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.

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